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HEALTH PROGRAM

HEALTH SYSTEM STRENGTHENING COMPONENT

Financed by USAID and implemented by Abt Associates in collaboration with Group ISSA, CRDH, ACA, PATH, FHI and Broad Branch

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ANNUAL REPORT – October 2011 to September 2012

Signing in Kolda of first performance contracts under the pilot phase of the performance-based financing initiative

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Abbreviations and Acronyms

ACA	Association Conseil pour l'Action
AIDS	Acquired Immuno-Deficiency Syndrome
ARD	*Agence Régionale de Développement* / Regional Development Agency
AWP	Annual Work Plan
BAP	*Bureau d'Appui au Projet FBR* / PBF Project Support Bureau
BTC	Belgian Technical Cooperation
CACMU	*Cellule d'Appui à la Couverture Maladie Universelle* / Support bureau for Universal Health Coverage
CAFSP	*Cellule d'Appui au Financement de la Santé et au Partenariat* / Healthcare Financing and Partnership Support Unit
CAS/PNDS	*Cellule d'Appui et de Suivi du PNDS* / Support and Monitoring Unit of the National Health Development Plan
CDD	*Comité Départemental de Développement* / Departmental Committee for Development
CLD	*Comités locaux de développement* / Local development committee meetings
COP	Chief of Party
CRDH	Centre de Recherche pour le Développement Humain
CRG	*Comité Régional de Gestion dans le cadre du projet FBR* / Regional management committee of the PBF project
CSO	Civil Society Organization
CTGP	*Comité Technique de Gestion du Projet* / Project Management Technical Committee
DAGE	*Direction de l'Administration Générale et de l'Equipement* / Directorate of General Administration and Equipment
DECAM	Expansion of health insurance coverage in a decentralization context
DF	Direct Financing under USAID direct assistance modalities
DHMT	District Health Management Team
DMO	Chief District Medical Officer
EIPS	Health Policy Initiative Group
FNG	*Fonds National de Garantie* / National Guarantee Fund
FHI	Family Health International
FNSS	*Fonds National de la Solidarité dans la Santé* / National Solidarity Fund for Healthcare
H2S	Health System Strengthening Component
ICP	*Infirmier Chef de Poste* / Chief nursing officer at health post
ISSA	Innovations des Systèmes de Santé en Afrique
MEF	Ministry of Economy and Finance
MHO	Mutual Health Organization
MOH	Ministry of Health and Social Action
MTEF-Health	Medium Term Expenditure Framework for the health sector
NGO	Non-Governmental Organization
ORCAP	*Outil de Renforcement des Capacités par l'Auto-évaluation Participatives* / Capacity development tool through self-evaluation
PAMAS	*Programme d'Appui à la Micro Assurance Santé au Sénégal* / Support program for health micro insurance in Senegal
PMP	Performance Monitoring Plan
PBF	Performance-Based Financing
PBM	Performance-Based Management
PLWHA	Person Living With HIV/AIDS
PNA	National medical store
PNDS	*Programme National de Développement Sanitaire* / National Health Development Program
RHMT	Regional Health Management Team

RMO	Chief Regional Medical Officer
SDP	Service Delivery Point
TFP	Technical and Financial Partner
UEMOA	*Union Economique et Monétaire de l'Afrique de l'Ouest* / West African Economic and Monetary Union
UNICEF	United Nations Children's Fund
URMS	*Union Régionale des Mutuelles de Santé* / Regional federation of mutual health organizations
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

The Health System Strengthening (H2S) Component is one of USAID/Senegal's assistance instruments under its 2011-2016 Health Program. It is based on the strategic directions set out in the National Health Development Plan (PNDS) for 2009-2018. The main objective of the Component is to improve the performance of the decentralized (regional and district levels) public health system supported by effective and efficient policies, planning and budgeting at the central level of the Ministry of Health and Social Action (MOH). The Component is expected to contribute significantly to the achievement of Intermediate Result 3 of the Health Program's results framework: "Improved performance of the health system". This will be realized through "improved management of district and regional health teams" (Intermediate Result 3.1) and "improved health system performance through development and implementation of national level policies" (Intermediate Result 3.2). The H2S Component works at the central level and in ten regions (Diourbel, Fatick, Kaffrine, Kaolack, Kolda, Louga, Sédhiou, Thiès, Ziguinchor, the departments of Pikine and Rufisque in the Dakar region).

USAID/Senegal signed a cooperative agreement with Abt Associates Inc. to serve as the implementing agency of the Health System Strengthening Component: CA# AID-685-A-11-00002 (2011-2016). Abt Associates put up a multi-disciplinary team of Senegalese experts, Senegalese organizations and international sub-contractors to implement the H2S Component. In addition to Abt Associates Inc., the H2S team comprises Groupe Innovations et Systèmes de Santé en Afrique (Group ISSA), Association Conseil pour l'Action (ACA), Centre de Recherche pour le Développement Humain (CRDH), Family Health International (FHI360), PATH and Broad Branch Associates.

Achievements during Year 1

The action plan for Year 1 (October 2011 to September 2012) of the H2S Component is based on priorities defined by the MOH and USAID. Year 1 activities focused on building a strong platform and developing tools for the extension of its interventions to all regions covered by the Component as of the Program's second year. Despite political tensions and security issues during the six months prior to the presidential elections of March 2012, significant progress was made towards achieving the Component's expected results. Achievements of the H2S Component during the first year are summarized below under its four sub-components: (i) Management and health systems at regional and district levels, (ii) Social financing mechanisms, (iii) Policies and reforms, and (iv) Coordination of the Health Program.

Management and health systems at regional and district levels. Activities of the sub-component "Management and health systems at regional and district levels" contribute to the attainment of Intermediate Result 3.1 "Improved management of district and regional health teams" of USAID/Senegal's Health Program. The combination of improved health system governance at the local level, enhanced capacities of regional and health district management teams, and the motivation of staff working at health huts, posts and centers on the basis of performance-based financing mechanisms will contribute to improving the efficiency and quality of healthcare service delivery and extending the coverage of priority healthcare services. These interventions are targeted at improving the quality and coverage of maternal health, family planning, child health, immunization, nutrition, malaria and tuberculosis services.

First year achievements under this sub-component contributed to the attainment of expected results set for the period. Key milestones towards improving health system governance at regional and district levels were reached with the revision of the training guide on health system governance, the orientation of district health management teams (DHMT) and regional health management teams (RHMT) in six regions (Dakar, Diourbel, Fatick, Kolda, Sédhiou and Ziguinchor) on health system governance, and data collection to inform indicators in all ten intervention regions of the Component. Strengthening the planning process at regional and district levels, adapting the financial management system of medical regions and health districts, developing a training guide and commencing training of regional (3 medical regions) and district (16 health districts) teams on administrative and financial management in the Kaolack, Kolda and Thiès regions are important milestones for capacity-building in planning, management and monitoring of health interventions at the regional and district levels.

Finally, the development of performance-based financing manuals, guides and tools will provide the MOH with greater time to introduce and extend the reach of performance-based financing mechanisms to improve coverage and quality of health services. PBF implementation has effectively commenced in the pilot districts of Darou Mousty, Kaffrine and Kolda: two hundred and thirty one (231) individuals have been trained on the PBF process in the Kaffrine, Kolda and Darou Mousty districts. Sixteen (16) beneficiaries have signed their performance contract out of the fifty three (53) planned during the H2S Component's first year: this under-performance is due to the fact that the decision of health workers' unions which are on strike to withhold health information is yet to be lifted.

Social financing mechanisms. Interventions under this sub-component focus on achieving Intermediate Result 3.2 "improved health system performance through development and implementation of national level policies" of USAID/Senegal's Health Program by improving financial access to healthcare for populations in general and vulnerable groups in particular. This is accomplished through the extension of health insurance coverage to informal sectors and rural populations.

Achievements under "social financing mechanisms" have allowed to progress towards the expected results of this sub-component. The finalization of draft decrees on the creation of the National solidarity fund for healthcare (FNSS), the National guarantee fund and the Administrative authority on social mutual assistance as well as the establishment of a platform for the harmonization of implementation mechanisms of the project to extend health insurance coverage within a decentralization context (DECAM project) are key stages towards building an environment likely to improve financial access to healthcare.

Furthermore, support has begun to enhance the capacities of local MHO networks to support the extension of health insurance coverage with the convening of meetings of departmental development committees (CDD) to mark the start of the DECAM project in the focus departments of Kaolack, Kolda and Louga, the conduct of a feasibility study on an MHO departmental network in each focus department (Kaolack, Kolda and Louga) under the DECAM project, the creation of twenty one (21) new MHOs and the restructuring of existing MHOs in pilot departments of the DECAM project. A total of four hundred and ninety three (493) MHO action committee members received training on how to promote MHO projects in local government units within focus departments where there are no MHOs: 180 in Kolda, 136 in Kaolack and 177 in Louga.

Finally, the mid-term evaluation of the PLWHA pilot project in the Kaolack region generated an information base and identified lessons that the H2S Component and its partners can build on to further strengthen health insurance coverage for vulnerable groups through MHOs. The evaluation report is available.

Policies and reforms. Interventions under the sub-component "national level policies and reforms" contribute to the realization of Intermediate Result 3.2 (Improved health system performance through development and implementation of national level policies) of USAID/Senegal's Health Program by strengthening capacities to develop health policies and improve resource allocation to support PNDS implementation.

Achievements of the first year have facilitated progress towards the attainment of expected results under this sub-component. The regular holding of meetings of the Health Policy Initiatives Group (EIPS), initiating the development of a community health policy by the EIPS, making progress in the establishment of a "Health Systems Strengthening" platform, and building the capacities of the PNA are all part of efforts to enhance health policy development and implementation capacities. Furthermore, key stages have been completed to improve allocation of healthcare resources and PNDS implementation. These include the production of the 2011 MTEF/Health performance report, the preparation of the 2012-2014 MTEF/Health and the preliminary 2013-2015 MTEF/Health as well as the commitment of the Directorate of General Administration and Equipment of the MOH to improve resource allocation and budget arbitration and monitoring. Finally, there was a significant shift during the course of the year in the expectations set out for the H2S Component by USAID, which mandated the Component to provide the MOH with support for the organization of national consultations on health and social action: a highly strategic activity that was not planned but called for the mobilization of significant resources of the Component. The Minister of Health and members of her cabinet visited the offices of the H2S Component to discuss the activities of the H2S Component as well as the national consultations on health and social action.

Coordination of the Health Program. Activities under the sub-component "Coordination and Monitoring/Evaluation" contribute to the realization of Intermediate Result 3.2 (Improved health system performance through development and implementation of national level policies) of USAID/Senegal's Health Program by ensuring coordinated implementation of the Program based on joint frameworks and support mechanisms and the functioning of monitoring frameworks and mechanisms.

Accomplishments under this sub-component during the first implementation year of the H2S Component facilitated progress towards expected results. An inter-agency platform was set up to strengthen coordination of USAID Health Program interventions. The five implementing agencies of USAID jointly prepared an operations manual for the three regional bureaus of the Health Program (Kaolack, Kolda and Thiès regional bureaus) and a per diem policy. They reached consensus on cost-sharing arrangements for regional bureaus. Implementing agencies also prepared a guidance note on integrated planning and a concept paper on direct financing to better adapt USAID's assistance modalities to the regional and local levels. Moreover, the H2S Component's PMP was validated in collaboration with USAID. Finally, quarterly progress reports of the Component were submitted to USAID on time and the preliminary action plans for the year beginning October 2012 to September 2013 as well as the FY2012 budget were also submitted to USAID.

Working documents and tools prepared by the H2S Component during Year 1 are listed in the box below. Most of these documents and tools are described in greater detail in this annual report and are key resources for the implementation of Program activities in the subsequent years.

Health System Strengthening Component
Documents and tools produced during Year 1

- Training manuals
  - Training manual on health system governance revised
  - Training guide on administrative and financial management of medical regions and health districts
- Procedures manuals
  - *Operations manual of the Health Program's regional bureaus*
  - Performance-based financing procedures manual
- Technical and concept notes
  - Capacity development tool through self-evaluation revised
  - *Guidance note on integrated planning*
  - *Concept paper on direct financing*
  - Concept paper on DECAM project revised
  - Four feasibility reports on departmental MHO networks; a summary report
  - Evaluation report on the PLWHA support pilot project in the Kaolack region
- Action plans and activity reports
  - Indicative program of the H2S Component
  - Annual action plan October 2011 – September 2012
  - Four quarterly progress reports of the Component
  - Preliminary Annual action plan October 2012 – September 2013
  - Bi-weekly updates

Note: Tools indicated in italic were prepared in collaboration with the other four implementing agencies (Intrahealth, FHI360, Childfund and ADEMAS) as part of efforts to better coordinate interventions of USAID/Senegal's Health Program.

Guidelines and priorities for Year 2

The annual action plan for Year 2 of the H2S Component will take into account changes in the sector and progress made during Year 1 of the Component. The presidential elections in March 2012 brought new authorities to power who have identified governance and universal health coverage as among the highest priorities on their political agenda. Furthermore, central and regional services of the MOH are currently being reorganized. In order to fit its priorities to these changes, the MOH is currently holding national consultations on health and social action (CONSAS) to discuss major themes such as health system governance and universal health coverage. Finally, USAID/Senegal is committed to implementing a package of reforms relating to the way it does business, including the *Implementation and Procurement Reform (IPR)* which introduces direct financing mechanisms at the central and regional levels with the support of implementing agencies.

In light of the above, the annual action plan for Year 2 sets the stage for the H2S Component to seize opportunities provided by the changing environment to improve health system performance, focus on the practical application of planning, management and financing instruments jointly developed by all Health Program components during Year 1, and maintain flexibility to ensure action plan interventions are in line with results and recommendations of national consultations on health and social action (CONSAS).

Based on these general guidelines, the following priorities directed the development of the 2012-2013 action plan:

- Consolidation of PBF in the three (3) pilot districts and extension to four (4) new health districts;
- Implementation of the Direct Financing pilot phase in regions where the Health Program's regional bureaus are located (Kaolack, Kolda and Thiès);
- Increased capacity-building in management and monitoring of medical regions and health districts in all intervention regions (Diourbel, Fatick, Kaffrine, Kaolack, Kolda, Louga, Sédhiou, Thiès, Ziguinchor, departments of Pikine and Rufisque in the region of Dakar);
- Consolidation of the strategic support framework of social financing mechanisms;
- Consolidation of the project to expand health insurance coverage within a decentralization context (DECAM project) in focus departments;
- Development of the community health policy;
- Advocacy work to reposition family planning;
- Strengthening the capacities of the National Medical Store (PNA) and the availability of drugs at the operational level;
- Consolidation of the Health Policy Initiatives Group (EIPS) and the Medium Term Expenditure Framework (MTEF) for the health sector as part of on-going organizational reforms within the MOH;
- Strengthening synergies between USAID Health program components.

Introduction

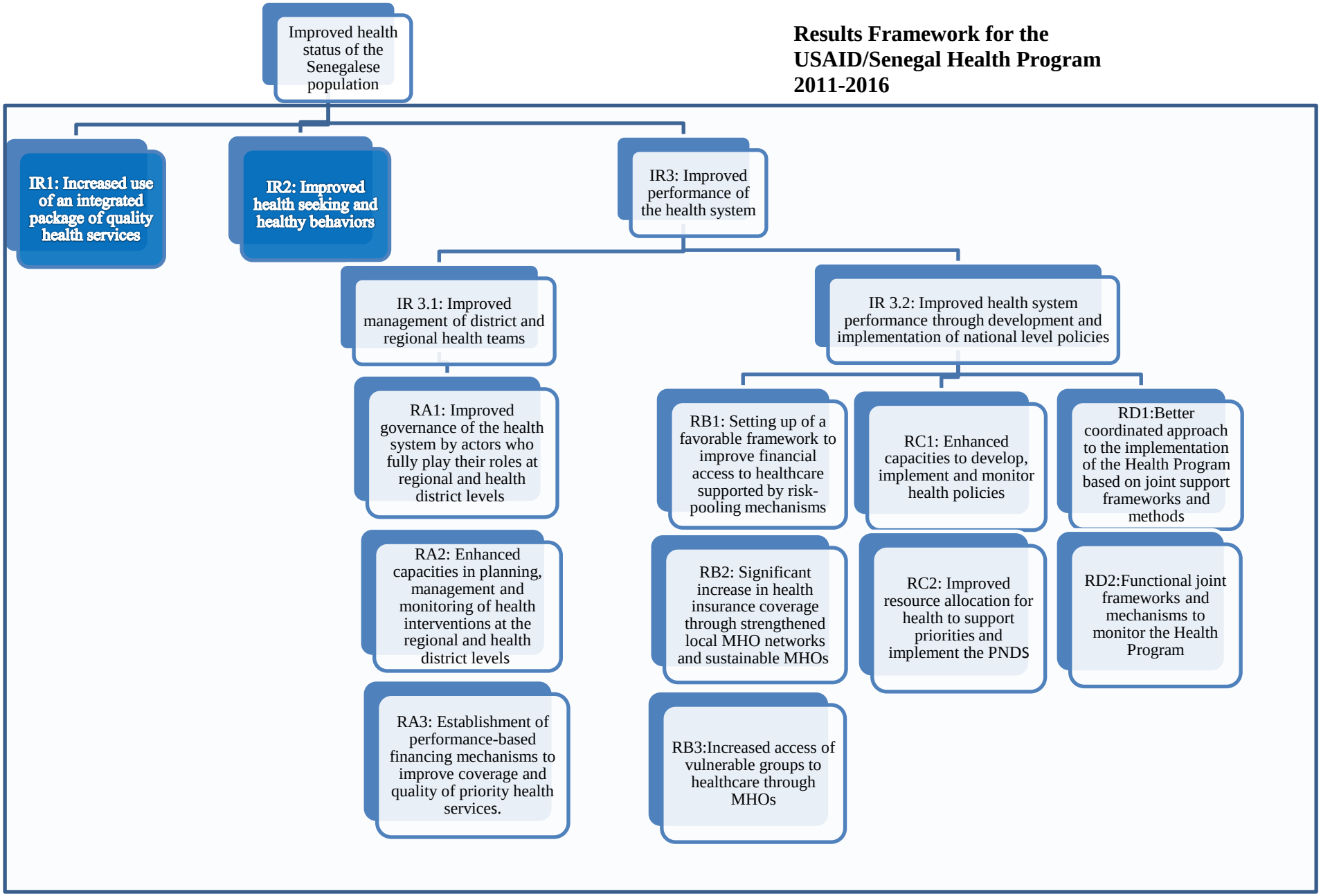
The National Health Development Plan (PNDS 2009-2018) is implemented via the four programs of the MTEF for health: (i) maternal, newborn, child and adolescent health, (ii) disease control, (iii) health system strengthening, and (iv) health system governance. Health system strengthening and health system governance are the strategic blueprint of the Health System Strengthening (H2S) Component of USAID/Senegal's 2011-2016 Health Program. These two programs focus inter alia on: (i) performance-based management, (ii) enhancing planning as well as administrative and financial management capacities in the sector, and (iii) reinforcing health insurance coverage by putting emphasis on vulnerable groups (mothers, children, pregnant women, the poor).

The H2S Component is one of USAID/Senegal's five assistance instruments under its 2011-2016 Health Program. The Development Objective of the Program is an "improved health status of the Senegalese population" and is to be reached through three intermediate results (IR): "Increased use of an integrated package of quality health services" (IR 1); "Improved health seeking and healthy behaviors" (IR 2); "Improved performance of the health system" (IR 3). The Health System Strengthening Component will contribute to achieving these intermediate results in collaboration with the four other components of the USAID/Senegal Health Program: (i) health services improvement, (ii) HIV/AIDS and Tuberculosis, (iii) community health, and (iv) health communication and promotion.

The main objective of the H2S Component is to improve the performance of the decentralized (regional and district levels) public health system supported by effective and efficient policies, planning and budgeting at the central level of the Ministry of Health. The H2S Component will contribute specifically to the realization of Intermediate Result 3 through "an improved management of district and regional health teams" (IR 3.1) and an "improved health system performance through development and implementation of national level policies" (IR 3.2).

USAID/Senegal signed a cooperative agreement with Abt Associates Inc., which has a long-standing reputation worldwide in health systems, health sector reforms and health financing reforms, to serve as the implementing agency of the H2S Component. In addition to Abt Associates Inc., the Abt team comprises Groupe Innovations et Systèmes de Santé en Afrique (Group ISSA), Association Conseil pour l'Action (ACA), Centre de Recherche pour le Développement Humain (CRDH), Family Health International (FHI), PATH and Broad Branch Associates. The H2S team submitted a technical proposal to USAID on the H2S Component as well as an indicative program focusing on the following four sub-components: (i) Management and health systems at regional and district levels, (ii) Social financing mechanisms, (iii) Policies and reforms, and (iv) Coordination of the Health Program. **Figure 1** summarizes the H2S Component's contribution to the Health Program's results framework through its sub-components and areas of action.

Results Framework for the USAID/Senegal Health Program 2011-2016



Expected results of the H2S Component are centered on key areas for improving performance of health systems. The "management and health systems at regional and district levels" sub-component will contribute to improving the efficiency and quality of healthcare service delivery through improved health system governance at the local level, enhanced capacities of regional and health district management teams, motivation of staff working at health huts, posts and centers to extend the coverage of priority healthcare services supported by performance-based financing mechanisms. The "social financing mechanisms" sub-component will focus on improving access to healthcare for populations in general and vulnerable groups in particular, by reducing financial barriers to healthcare and expanding health insurance coverage through mutual health insurance schemes and the support of government authorities. Finally, sustainable improvements in health system performance will be ensured with the creation of an enabling environment to support policy development, the enhancement of resource allocation for the sector, synergy and alignment of interventions with PNDS 2009-2018 priorities through the sub-components "Policies and reforms" and "Coordination of the Health Program".

The following priorities guided the development of the 2011-2012 action plan:

- Ensure that key tools (manual on governance, ORCAP, direct financing approach, administrative and financial management for medical regions and health districts) to enhance implementation of USAID/Senegal's Health Program are developed, tested and approved;
- Start the process of strengthening management capacities of medical regions and health districts in a selected number of regions;
- Provide support to the MOH for the effective start of the Performance-Based Financing pilot project during the first quarter of 2012;
- Contribute to the implementation of the pilot project on extending health insurance coverage within a decentralization context (DECAM project);
- Encourage the establishment of working groups or technical committees of the Health Policy Initiatives Group (EIPS) in priority areas (community health, health systems strengthening, resource allocation); and
- Provide technical assistance to the National Medical Store (PNA).

The annual report is divided into four (4) sections. The first section summarizes accomplishments of the Component during the first year. The second section analyzes problems encountered during activity implementation and the third section summarizes the financial execution of the Component. The fourth section identifies key changes in the immediate environment of the Component, as well as guidelines and priorities for its second year. The annual report is supplemented by two attachments: Attachment 1 summarizes the Component's financial report and Attachment 2 presents the PMP indicators of the Component.

1. Activities conducted in Year 1

Year 1 activities focused on building a strong platform and developing tools for the extension of interventions to all regions covered by the Component as of the Program's second year. This general guideline was adopted in order to focus efforts on achieving expected results regarding the many new initiatives supported by the Component, including capacity-building in administrative and financial management of medical regions and health districts, expanding the utilization of ORCAP, implementation of the pilot phase of the performance-based financing (PBF) initiative, development of direct financing mechanisms, implementation of the pilot project on extending health insurance coverage within a decentralization context (DECAM project), moderating the Health Policy Initiatives Group (EIPS), providing support to the PNA, and coordinating interventions of the Health Program. Hence, most of the H2S Component's efforts was focused on jointly developing tools not only with implementing agencies for a better coordination of interventions of the Health Program but also with MOH partners to ensure the start of pilot initiatives on healthcare financing (PBF, DECAM). Consequently, the activity report for Year 1 will present the main tools developed during the first year. These are key resources to enhance the performance of the health system and the legacy of the H2S Component to be accumulated over the next four years of the Health Program.

This section has five sub-sections. The first sub-section summarizes the start-up activities of the Component. The achievements of the H2S Component during the first year are then summarized in the ensuing four sub-sections. These achievements revolve around the following four sub-components: (i) Management and health systems at regional and district levels, (ii) Social financing mechanisms, (iii) Policies and reforms, and (iv) Coordination of the Health Program. In each sub-section, expected results of the sub-component are recapped, steps taken to reach milestones set by the Component in order to track progress towards achieving expected results are summarized, reasons why certain milestones were not reached are reviewed, and challenges as well as solutions proposed and lessons learned to steer future activities are summarized.

1.1. Start-up activities

Installation of the H2S team. The Abt team was progressively formed during the course of the first implementation year. Key members of the Abt team took up offices in November 2011. Sub-contractor agreements were signed in December 2011 though sub-contractors were temporarily mobilized from October to December 2011 on the basis of letters of agreement. During the second quarter, the recruitment process of the Coordinator at the Kaolack bureau, the regional adviser on health systems at the Thiès bureau and the adviser on social financing at the Kaolack bureau was finalized and contracts signed. The recruitment of administrative and financial officers of the Kaolack and Kolda regional bureaus was finalized and contracts signed during the third quarter.

A team-building workshop was organized in October 2011 to help the H2S team and strategic MOH partners gain a common understanding of the H2S Component and of USAID/Senegal's Health Program. Furthermore, the roles and responsibilities of H2S team members for the implementation of the H2S Component were identified. An indicative program of the H2S Component was developed by the Abt team based on the results of the team-building workshop (see planning activities below).

Setting up of offices at the national and regional levels. Setting up of the H2S Component's national office and the USAID Health Program's regional bureaus was completed during the first half of the year. The national offices of the AIRS and H2S projects, both implemented by Abt Associates, were

set up during the first quarter and are located within the same premises and share basic support functions.

During the previous Health program, the regional bureau in Kolda was located within the premises of the Kolda medical region and in light of the positive lessons derived from this experiment, USAID/Senegal requested that all three regional bureaus be located within the premises of the medical regions of Kolda, Kaolack and Thiès. With the assistance of the MOH, office space was provided to accommodate the regional bureaus of Thiès and Kaolack within premises of medical regions. Renovation works were completed in January 2012 at the Health Program's regional bureau in Thiès, located within the premises of the Thiès medical region. The staff moved into these newly renovated offices in February 2012. More extensive works were required to renovate the offices of the Health Program's regional bureau in Kaolack, located within the premises of the Maternal and Child Health Services of Kaolack. Staff of the Kaolack regional bureau moved into their offices in March 2012.

Acquisition of equipment. Equipment of the previous "Healthcare Financing and Policy" project were handed over to the Component and supplemented by new acquisitions following an assessment of additional needs. Firstly, most IT equipment was replaced. In this regard, a tender process was launched by head office for the procurement of new equipment. Part of this equipment was delivered to the national bureau and the rest to regional bureaus. Secondly, the extra furniture from the national bureau was transferred to the Kaolack regional bureau. New acquisitions were made to fully address the furniture and equipment needs of the Kaolack regional bureau. New furniture was procured to address the additional needs of the Thiès and Kolda regional bureaus. The H2S Component also purchased four new Toyota vehicles to add to its motor pool: one (1) vehicle was delivered to each regional bureau and one (1) to the national office.

Meetings with clients and key partners. The H2S Component participated in the various orientation sessions organized by USAID on contracting and technical aspects. Furthermore, the Component invited USAID or other components of the Health Program to directly participate in some of its strategic activities, whenever necessary. H2S also initiated a series of bilateral meetings with other implementing agencies to discuss jointly managed activity areas, in accordance with their respective mandates, for a better coordination of interventions. Central-level services of the MOH (CAS/PNDS, DAGE and CAFSP), identified as the main partners of the H2S Component, were closely involved in the latter's operational planning process. Along the same lines, the H2S Component held meetings with WHO (P4H representative) and the BTC to strengthen collaboration in the field of health insurance coverage. The Component also met with the health team of the World Bank Dakar office.

Participation in the launch of the USAID Health Program. The H2S Component coordinated the preparatory activities and the organization of the ceremony to launch USAID/Senegal's 2011-2016 Health Program. The H2S Component took over from the Healthcare Financing and Policy Component as coordinator of the technical committee in preparation of the launch ceremony. During this ceremony, the H2S Component moderated the panel on Health system governance and participated in other sessions where it presented its approach to supporting the development of MHOs in Senegal, particularly its experience with mechanisms for providing protection to vulnerable groups through MHOs. Like other components of USAID/Senegal's 2011-2016 Health Program, it also presented two posters at this ceremony (one on the results of the former program and another on the new program).

Planning activities. Planning activities during the start-up period centered on the development of an indicative program covering the five years of the Program, an annual action plan for 2012 and a monitoring and evaluation plan of the Component. The indicative program of the H2S Component for 2011-2016 was developed in order to make clearer the contents of its interventions over this period in accordance with the mandate entrusted by USAID. The usefulness of this document lies in the fact that it serves as a benchmark for annual planning. It especially helps to ensure a better monitoring of project implementation as focus is constantly maintained on *milestones* that make it possible to measure overall progress towards the attainment of expected results at the end of the Health Program.

The 2012 annual action plan was prepared in a participatory manner at the national and regional levels. The Abt team worked in close collaboration with DAGE, CAS/PNDS, DLSI and CAFSP to produce the first draft of the annual action plan in November. This first draft was submitted to the AOTR of the Component on 29 November 2011 and was used as a reference document by the Abt team during their participation in the AWP development process in health districts and medical regions. It was at this stage that activities supported by the H2S Component were included in AWPs of focus regions. The 2012 annual action plan was finalized and submitted to the AOTR of the Component on 30 December 2011 after incorporating the comments and suggestions of USAID/Senegal's as well as the conclusions of MOH planning activities (at central and regional levels).

The first draft of the monitoring and evaluation plan of the H2S Component was developed. A list of indicators based on the preliminary list attached to the technical bid of Abt Associates Inc. and its partners was proposed and an initial meeting held with the USAID monitoring and evaluation specialist. This list was discussed and validated with USAID.

1.2. Sub-Component A: Management and health systems at regional and district levels

1.2.1. Expected results and milestones for Year 1

The following table recaps milestones set for this sub-component to track progress towards achieving expected results for Year 1 of the H2S Component. The Component, by achieving its results (RA1, RA2 and RA3) under the "management and health system at regional and district levels" sub-component will contribute to the attainment of USAID/Senegal's Health Program Intermediate Result 3.1 "Improved management of district and regional health teams". The combination of an improved health system governance at the local level, enhanced capacities of regional and health district management teams, and the motivation of staff working at health huts, posts and centers on the basis of performance-based financing mechanisms will contribute to improving the efficiency and quality of healthcare service delivery and extending the reach of priority healthcare services. Performance of healthcare providers in relation to activities under this sub-component will be evaluated using health indicators on maternal health, family planning, child health, immunization, nutrition and tuberculosis as well as quality indicators.

Expected results of the H2S Component	Milestones for Year 1
R.A 1: Improved governance of the health system by actors who fully play their roles at regional and health district levels	• The *Guide du Médecin-Chef du Centre de Santé* (guide for chief medical officers at health centers) is developed • The MOH guides for chief medical officers at the regional and district levels and for chief nursing officers at health posts are reviewed and updated • Training guide on health system governance is updated • Stakeholders at medical regions and health districts are trained on governance and leadership in three (3) regions (ZG, SD and KD)
R.A2: Enhanced capacities in planning, management and monitoring of health interventions at regional and health district levels	• The ORCAP tool is utilized in three (3) regions covered by the Health Program • Evaluation of the ORCAP tool is conducted • A training guide on administrative and financial management as well as an accounting software for regional and district teams are developed • Regional and district teams are trained on administrative and financial management in three (3) regions • A national workshop to build consensus on direct financing is held • Annual joint portfolio reviews are held in five (5) regions
R.A3: Establishment of performance-based financing mechanisms to improve coverage and quality of priority health services.	• PBF manuals, guides and implementing tools are developed • PBF mechanisms are implemented in three (3) pilot districts • Incentives for PBF project beneficiaries are paid on time

Achievements during the first year enabled progress in the attainment of expected results set for the sub-component. Key milestones towards improving health system governance at regional and district levels were reached with the revision of the training guide on health system governance, the orientation of district health management teams (DHMT) and regional health management teams (RHMT) on health system governance and data collection. Strengthening the planning process at regional and district levels, adapting the financial management system of medical regions and health districts, developing a training guide and commencing training of regional and district teams on administrative and financial management are important milestones for capacity-building in planning, management and monitoring of health interventions at the regional and district levels. Finally, the

development of performance-based financing (PBF) manuals, guides and implementing tools as well as the effective start of PBF in the pilot districts of Darou Mousty, Kaffrine and Kolda will provide the MOH with more time to introduce and extend the reach of performance-based financing mechanisms to improve coverage and quality of priority health services.

1.2.2. Health system governance and leadership

Review of the training guide on health system governance. The training guide on health system governance was revised by the MOH with support from the three regional bureaus of the USAID Health Program. A revision workshop attended by the three regional bureaus and representatives of CAFSP/MOH was held in Kaolack. Furthermore, a validation workshop was organized by the H2S Component with the participation of representatives of MOH central services (Cabinet, DAGE, CAS/PNDS, DS), representatives of locally-elected officials, civil society and other TFPs. The training guide on health system governance was finalized incorporating all observations made during the validation workshop and taking into account the reorganization of the Ministry of Health. A participant's handbook was also prepared (see Box A1 on the training guide on health system governance).

Box A1: Training guide on health system governance

The main objective of the training guide on health system governance is to strengthen the capacities of health actors in health governance so as to improve the quality of health system management. For this purpose, the guide is divided into five chapters: (i) The structure and operation of the health system in Senegal; (ii) Definition of the concept of governance in general and particularly health governance in Senegal; (iii) Definition of strategic priorities of health governance in accordance with PNDS guidelines; (iv) Identification of strategies to improve health system governance; and (v) Presentation and review of health system governance indicators.

This training guide on health system governance is developed by the H2S Component as part of efforts to strengthen the capacities of actors at the central, intermediate and operational levels of the health system. It is a well-planned and useful tool for services and departments under the Ministry of Health, regional and district health management teams, healthcare providers, heads of management organs of health districts, heads of local government units and associations of locally-elected officials, civil society organizations, administrative authorities, technical services and development partners. It provides up-to-date information on the health system in general and on PNDS health system governance in particular. It can be used during training and/or orientation sessions of RHMTs, DHMTs and all other actors in the health system.

Other achievements. The three regional bureaus of the Health Program provided support at various stages to RHMTs and DHMTs in Abt's intervention zone to collect data and discuss indicators on health system governance. Indicators on health system governance were updated based on indicators used in the PMP of the H2S Component. Meetings were held to brief stakeholders and to prepare data collection cards. In an effort to ensure increased accountability and ownership of this activity by local teams, data was gathered by members of district health management teams whereas medical regions compiled and summarized the data. Finally, results were presented to managers of health districts and medical regions as planned.

Difficulties encountered on the road to reaching milestones. Development of the Guide for chief medical officers at health centers and the revision and updating of the Guide for chief regional medical officers, chief district medical officers and chief nursing officers at health posts could not be conducted due to impending reforms on regional health services: the effective implementation of these reforms could shift the focus of the various guides to be revised. Regional training workshops on health system governance were planned for RHMTs and DHMTs in the various regions covered by the Program. However, these activities have been moved to Year 2 as a result of the delay in

finalizing the documents. Finally, training stakeholders on leadership is subject to the development of the training guide on leadership planned in Year 2.

1.2.3. Capacities in planning, management and monitoring

Regional workshops to consolidate annual work plans (AWP) of health districts and medical regions. Regional bureaus of the Program provided technical and financial support to medical regions for the organization of workshops to consolidate annual work plans. Joint teams comprising representatives of all components, both national and regional staff, were formed and participated in ten regional workshops on the consolidation of 2012 AWPs. This was an opportunity to exchange with RHMT/DHMTs on the new USAID 2011-2016 Health Program and to integrate first year activities of the various components into AWPs of districts and medical regions.

ORCAP planning tool. The ORCAP tool was revised based on feedback from local actors. A revised version of the six Service Delivery Areas (SDA) is now available as well as the revised version of the User's guide and lexicon. Moreover, the financial management section was revised and amended to include relevant areas. The revised tool was shared with regional bureaus of the USAID Health Program and with the Department of Planning at the MOH to ensure its utilization along with other planning and health system strengthening tools.

Box A2a: ORCAP tool

In 2011, the Ministry of Health through the AIDS and STI Division (DLSI) received funding for health system strengthening activities in Round 9 of the Global fund to fight AIDS, tuberculosis and malaria. To help medical regions prepare for this major funding, FHI360 and DLSI jointly developed the Capacity-building through participatory self-evaluation tool (ORCAP). It was initially used in the 3 HSS priority regions (Ziguinchor, Kolda and Sédhiou). Since then and within the framework of a sub-contract between Abt and FHI360 for the implementation of the H2S Component, FHI360 has improved the content and application process of the tool and has proposed a plan to extend its utilization to other regions.

ORCAP is designed to enable medical regions implement priority actions that are necessary to enhance their performances. The tool makes it possible to conduct an institutional assessment of organizational, financial and technical management aspects, identify capacity-building actions in priority areas and optimize resources injected in the region. ORCAP is a self-assessment tool designed for use by medical regions and health districts. It is structured around the six (6) Service Delivery Areas (SDA) that represent the cornerstones of the reference framework defined by WHO in 2007 on health systems strengthening. Its application fosters open dialogue among staff members to identify strengths and weaknesses of the medical region hence resulting in the formulation of consensual actions to strengthen the capacities of the medical region based on priorities identified: these actions are then included in the AWP of the region.

Capacity and needs assessment in administrative and financial management of medical regions and health districts. With a view to strengthening management capacities at regional and local levels, the H2S Component, through ACA, assisted DAGE/MOH in the development of an administrative and financial management needs assessment guide for RHMTs and DHMTs. A situational analysis on the administrative and financial management of health facilities was conducted with the participation of various actors (DAGE, IntraHealth, Abt and ACA). The mission consisted of collecting information on administrative and financial management by conducting interviews using a questionnaire that was validated during a meeting at the MOH and reviewing management documents. A sample of 16 health facilities including medical regions, health districts, health centers, health posts and EPS' were visited.

Adaptation of the financial management system and development of a training guide. In order to have an appropriate financial management system and develop a training guide adapted to the realities on the ground, members of the team that conducted the needs assessment mission met for a

four-day workshop. Tools were developed to strengthen the capacities of medical regions and health districts on the basis of financial management weaknesses identified. These tools were then categorized per subject and grouped under training themes. Learning objectives were determined for each theme.

The system designed addresses the concerns of partners, the ability of managers to take over the system in view of their profile, the need for high quality AWPs, the desire to have an integrated system that can allow for the accounting of funds from different partners, etc... It includes the bank account ledger, supporting documents and their filing and archiving system, bank reconciliation statements, the transactions control system, requests, budget monitoring, financial monitoring of partners, periodic financial reports, financial management standards, security of funds, and the roles and responsibilities of financial management stakeholders. A guide was developed to conduct training sessions on the approved financial management system (see **Box A2B**).

Regional and district teams are trained on administrative and financial management in the Kaolack, Kolda and Thiès regions. Three-day workshops moderated by regional advisors with the assistance of DAGE and PAGOSSAN (Belgian Technical Cooperation project) were held in Thiès, Kaolack and Kolda. The workshops were attended by managers of medical regions and health districts in the three regions in charge of accounting and record-keeping in health facilities within these areas. Planning officers involved in the management of these activities were also associated. Other actors involved in the process also participated in these sessions including managers of regional health training centers in Thiès and Kolda, administrative and financial officers of the USAID Health Program's regional bureaus in Thiès and Kaolack. A total of 32 participants (28 men and 4 women) participated in the workshops – 13 in Thiès, 13 in Kaolack and 6 in Kolda. Sessions focused on documents of the accounting and financial management system as well as on other materials. These include budget monitoring reports, partner follow-up reports, financing requests, bank account ledgers, payment vouchers, bank reconciliation statements and financial reports.

Box A2b: Training guide on financial management of medical regions and health districts

The training guide on financial management is developed for facilitators to present the financial management system using a gradual and precise method. It also ensures that workshops are conducted in a consistent manner and in compliance with the techniques and principles for participation, practical training and strong ownership of the training content.

The trainer's guide is divided into three parts. The first part comprises the introduction which briefly summarizes the background to the development of the guide, the target population, the general learning approach to be adopted and the various training themes. These include: AWPs and budget monitoring, financing requests, account monitoring and charges, external expenditures, supporting documents and their filing system, bank reconciliation, financial reports, evaluation and conclusion of workshop. The second part covers the outlines for thematic sessions. A plan is developed for each thematic session to be properly conducted. It includes the objectives of the session, the average duration and key components of the session as well as the list of learning materials and aids to be used by the facilitator. The third part focuses on practice questions and answers for participants to work on in order to familiarize themselves with financial management documents and procedures.

The guide was first prepared by the three advisers on administrative and financial management at regional bureaus based on the outcome of the needs assessment conducted in medical regions and health districts and ACA's experience in developing management tools and facilitation techniques. It was then presented to the DAGE, the Abt team and to other partners. Emphasis was placed on system documents and tools indicating for each document, its purpose and when to use it. Observations and suggestions of participants were taken into account. Finally, the guide was tested to make sure it is adaptable and can be easily understood. In this regard, facilitators from ACA, DAGE and PAGOSAN met in Dakar to put up teams in charge of conducting the various thematic sessions planned.

The following recommendations were made at the end of the training session: ensure the availability, as soon as possible, of system documents in medical regions and health districts; ensure regular and close monitoring of training sessions; extend the duration of a training session to 4 days so as better capture their content; develop a handbook for the accounting and financial management system; provide guidance to other actors involved in the management of the system, particularly RHMTs and DHMTs including RMOs and DMOs; organize events for managers to exchange on the accounting system; encourage financial partners to adopt a harmonized system for the management of funds granted to medical regions and health districts; conduct a training session on the management of equipment and supplies (stock accounting); and expedite the development of the software version of the accounting system.

National workshop to build consensus on direct financing. USAID/Senegal requested implementing agencies of its Health Program to assist in the development of a direct financing mechanism to better adapt its assistance delivery methods to regional and local levels. Agencies mandated the inter-agency working group on "Financing and Sustainability" to design a direct financing mechanism adapted to the regional level (**see section 1.5** on program coordination). Under the leadership of the H2S Component, Abt Associates and the sub-contractor FHI360, implementing agencies have since January 2012 organized several workshops and meetings among themselves as well as with USAID/Senegal and the MOH to develop the concept paper on direct financing (see **Box A2C on the direct financing concept paper**).

Box A2c: Concept paper on direct financing

The direct financing mechanism, developed by agencies and validated by USAID/Senegal, is based on the underlying principles of the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008). It has five pillars. The "services package" pillar identifies all services and activities eligible for procurement and payment under the direct financing mechanism. During the current introductory phase of the direct financing mechanism, the services package is limited to activities in five areas: (i) strengthening the capacities of medical regions, districts and health committees, (ii) planning, monitoring and evaluation, (iii) coordination of interventions, (iv) health promotion activities, and (v) strengthening the management system of drugs and specific products. Services and activities to be implemented during a given period are jointly identified by stakeholders through a planning process, which is the second pillar. The third pillar consists of the contracting method, which is based on a "fixed contract" model signed between USAID agencies and the medical region. The fourth pillar relates to payment methods, specifying the conditions for the transfer of resources and the disbursement of funds by technical and financial partners in favor of beneficiaries. The fifth pillar defines the reporting and monitoring mechanism.

The direct financing mechanism is one of the shared tools jointly developed by implementing agencies of the USAID Health Program. The different stages of its preparation included: (i) the definition of principles and pillars by a technical group; (ii) the definition by agencies and representatives of the Ministry of Health, including medical regions, of options under each pillar as well as the tools and criteria for their evaluation; (iii) the validation of options for each pillar by the USAID Health Team; and (iv) the compilation of data and feedback from medical regions and regional bureaus. The next stages are the presentation of the model to the Ministry of Health, the production of a procedures manual and the training of actors on how to use the model. The direct financing mechanism will be implemented in two phases: a pilot phase in 2013 to be conducted in 3 test regions where regional bureaus of the Health Program are located (Thiès, Kaolack and Kolda) and an extension phase in 2014-2016 to all regions covered by the USAID Health Program.

Joint annual portfolio reviews. The H2S Component provided support to ten (10) regions in its intervention zone to prepare and organize their joint annual portfolio reviews (JPR) attended by all actors in the health sector, namely, administrative authorities, local government units, heads of departmental services, development partners, NGOs and civil society. These regional JPRs were an opportunity for RMOs to report on the performances of the health sector in 2011 in their respective regions and to identify constraints and difficulties faced during activity implementation. The following conclusions can be reached after analysis of the various JPR reports: (i) the decision of labor unions to withhold health information has a negative impact on data quality, (ii) health districts

are faced with difficulties to mobilize decentralization subsidy funds, (iii) human resources and logistical means are lacking, (iv) there is no linkage between the various planning documents, and (v) activities with the different partners working in the regions are poorly coordinated.

Monitoring of AWP implementation at the district level. The Kolda regional bureau assisted the Kolda medical region in the organization of a workshop to monitor AWP implementation in the three districts within the region as well as in the medical region and the regional hospital. Two quarterly AWP monitoring meetings were organized by the Kaolack medical region with the technical and financial support of the H2S Component through the Kaolack regional bureau. The regional bureau in Thiès provided assistance to the four regions it covers in the organization of workshops to monitor AWP implementation. The following were noted at these monitoring workshops: (i) there are delays in the setting up of funds for activity implementation; (ii) there is a communication deficit between certain partners and the districts; (iii) there is a low level of participation of local government units and other members of management organs in AWP monitoring bodies; (iv) a proposal to improve the AWP monitoring template was made; (v) meetings to monitor AWP implementation should be included on the agendas of health districts and medical regions; and (iv) documents and lessons learned in the implementation of AWP activities should be shared.

Support for the establishment of regional consultative bodies. During the first year, the H2S Component provided support to the Kaolack, Kaffrine and Louga regions to set up a consultative body in each region. The functioning of these bodies and the regular convening of their meetings remains a major challenge. Avenues for cooperation between DAHW and the USAID Health Program, particularly in the area of TB/Leprosy, were also identified in the Thiès, Fatick, Kaolack and Kaffrine regions.

Assistance during quarterly coordination meetings of medical regions. Support was provided for the organization of seven (7) coordination meetings by the Thiès regional bureau (2 at the medical region of Dakar, 2 at the medical region of Diourbel, 1 at the medical region of Louga and 2 at the medical region of Thiès), two (2) in the Sédhiou and Kolda regions by the Kolda regional bureau and five (5) quarterly coordination meetings in the Kaolack (02) and Kaffrine (03) regions by the Kaolack regional bureau. Progress in the implementation of activities conducted by health districts and medical regions was assessed during these quarterly meetings. Results were mixed due to the withholding of health information. It was suggested inter alia to ensure the functioning of consultative bodies and the monitoring of 2012 AWPs.

Assistance to medical regions in the supervision of districts. Two (02) quarterly supervision missions to health districts were organized by the medical region of Kaolack. The regional bureau in Thiès supported four (04) supervision missions in its intervention zone and the Kolda medical region received support from the regional bureau for the integrated supervision of the districts of Kolda, Vélingara and Médina Yoro Foulah.

1.2.4. Performance-Based Financing

Development of manuals, guides and tools to conduct Performance-Based Financing (PBF). Support provided by the H2S Component during the first half of Year 1 was focused on finalizing the project document, the procedures manual, legal instruments and technical tools of the PBF initiative. The regulatory and institutional framework of the PBF project was finalized by means of an order signed by the MOH. This order was discussed beforehand with the Ministry of Finance, local government units, medical regions, civil society, social partners and technical and financial partners

working in the health sector. Administrative measures were taken to set up a PBF project support bureau (BAP) within the Ministry of Health and office memos designating members of the steering committee and the project technical and management committee (CTGP) were signed. Implementation was effectively launched at the regional level through CRD meetings chaired by the governors of the various regions and this facilitated the mobilization of support from regional authorities and the establishment of the PBF initiative's regional management committees (CRG).

Effective start of PBF implementation in the pilot districts of Darou Mousty, Kaffrine and Kolda. PBF effectively commenced in pilot districts during the 3rd quarter of the H2S Component's first year of implementation (April 2012). The Component helped the MOH to share and disseminate information on this initiative at the regional level. Meetings of regional development committees (CRD) chaired by the governors and departmental development committees (CDD) chaired by the *préfets* were organized in pilot areas. Participants exchanged views on the pilot project with officials of the MOH and the three CRDs organized were attended by One hundred and forty seven (147) stakeholders (65 in the Kolda region, 30 in Kaffrine and 52 in Louga). The Kolda regional bureau of the USAID Health Program assisted the health district in the organization of information meetings at the community level with locally-elected officials and CBOs.

Box A3a: Performance-based financing procedures manual

The purpose of the procedures manual for Performance-Based Financing (PBF) is to describe the operation of management organs, harmonize the training of actors and document tools and procedures employed to ensure optimal performance monitoring. The manual comprises six (6) chapters which discuss the five key stages of the PBF cycle and the evaluation of the pilot project. The five stages are: (i) performance contracts; (ii) reporting and monitoring; (iii) audit; (iv) payments; and (v) reviews and revisions. The manual is revised periodically to reflect any changes in the various design elements, implementation procedures or management tools.

The manual was developed by members of the Project technical and management committee (CTGP) comprising representatives of different MOH services with the support of technical and financial partners. USAID provided the technical committee with international technical assistance under the H2S Component from the early stages of project design.

The manual is mainly designed for use by trainers, health workers in regions concerned, actors engaged in the design and implementation of the pilot project as well as all persons interested in PBF in Senegal. It provides management organs, beneficiaries and auditors with a tool best suited for PBF implementation.

Orientation workshops on the PBF process were held beforehand for staff of implementing agencies of the USAID Health Program and members of the Health Policy Initiatives Group of the Ministry of Health: see section 1.4.

Two hundred and thirty one (231) individuals trained on the PBF process in the Kaffrine, Kolda and Darou Mousty districts. Training sessions on PBF were organized by the CTGP in the three pilot districts with the support of the Abt national office and regional bureaus of the USAID Health Program. The three-day sessions were attended by beneficiaries (DHMT members, staff of health centers, EPS1 and health posts), medical region staff, representatives of local government units, representatives of the MEF at the local level, MHOs, NGOs, health committees and social partners. A total of two hundred and thirty one (231) individuals were trained on the PBF process including 81 in the district of Kolda, 80 in the district of Kaffrine and 70 in the district of Darou Mousty. The effective participation of all actors and their interest in this training are guarantees for successful project implementation. The Component provided assistance for the reproduction of the pilot project document and the procedures manual, which were distributed to all participants at PBF training sessions. It is worth noting that the involvement and participation of regional bureaus through **Coordinators and HSS advisers** of the H2S Component was commended by the MOH.

Technical and financial support provided by the H2S Component for implementation of the PBF pilot project also focused on conducting the baseline survey and documenting practices of the PBF pilot phase. These two activities were entrusted to CRDH, a sub-contractor of Abt Associates, which has the required skills to properly carry out both assignments. The CRDH team worked in close collaboration with the CTGP and Abt advisers to develop a survey protocol and data collection tools. The objectives of the baseline survey were defined, as well as its geographic focus, scope, sample size and estimated budget. Three questionnaires (for women, households and health facilities) were prepared and validated by a select committee of the PBF group. The documents were submitted to the MOH's ethical and research committee, which gave clearance to CRDH.

Following the decision to integrate the household component of the PBF survey into the continuous survey to be conducted by ANSD, CRDH in collaboration with the project management technical committee (CTGP) finalized the tools for the baseline survey at service delivery points. The purpose of this survey is to gather data in health facilities within pilot districts in order to produce indicators for the definition of targets in performance contracts. After gathering data, CRDH prepared a draft report which was discussed among BAP team members, the CTGP chair, Abt and Childfund. A presentation meeting was organized with CTGP members and the results of the survey sent to DMOs.

Activities relating to the documentation process began during the third quarter of FY2012. A CRDH team participated in the training on PBF in the Darou Mousty district, in meetings of CRDs and CDDs in pilot areas as well as in a mission to supervise and assist health facilities in the district of Kaffrine to prepare their documents.

The H2S Component provided support for the organization of missions to present baseline references and to negotiate and sign PBF performance contracts in the three pilot districts. In each district, draft contracts are prepared by the CTGP team after validation of baseline references for all beneficiaries and approved by the heads of recipient facilities. The signing ceremony between the chief regional medical officer (RMO), signing on behalf of the MOH, and managers of recipient facilities was organized at the end of the mission.

Only sixteen (16) out of fifty three (53) performance contracts were signed. Most beneficiaries in the three pilot districts refrained from signing following an order from the labor union SUTSAS-SAS, consistent with its decision to withhold health information. These include seven (7) health posts, a health center and the DHMT in Kolda and six (6) health posts and the DHMT in Kaffrine. The Director of the EPS1 of Kaffrine is yet to sign the contract because he believes that certain PBF indicators are not adapted to their role as a referral facility. No contracts were signed in the health district of Darou Mousty by beneficiaries as a result of the aforementioned decision of the labor union.

In collaboration with the PBF adviser of the H2S Component, the BAP organized missions to supervise and provide assistance for the utilization of PBF tools in the Kolda and Kaffrine districts. CRDH and Broad Branch participated in the Kaffrine mission as part of activities to document the process. Problems encountered by beneficiaries during project implementation were discussed during these supervision missions. These relate mainly to the lack of back-up measures (personnel, logistics, and equipment) and frequent stock-outs of drugs especially SP, vitamin A and certain family planning products. The mission enabled the BAP in collaboration with the Component, to provide beneficiaries with assistance to prepare quarterly performance reports, fill-out the checklist on quality and submit payment requests. The team noted the commitment of healthcare providers, who are

aware of the positive impact PBF can have on healthcare facilities and on the quality of care. Some have even begun to take complete ownership of the project and are taking initiatives for improvement.

The H2S Component also provided support in preparation of joint audit missions with the recruitment of the audit firm and community-based organizations (CBO). For the recruitment of the audit firm, the BAP sought the expertise of the Ministry of Economy and Finance's project support unit (CAP) to conduct the selection process. CBOs were selected by CRGs with the support of the regional bureaus in Kaolack and Kolda. For the first joint audit mission, Abt and members of the BAP met with the selected audit firm to discuss measures to be taken to ensure compliance with rules and procedures. The terms of reference of the mission were prepared by the BAP, the training of auditors planned and the first joint audit mission is scheduled at the end of October 2012.

Within the framework of implementing reforms on USAID's assistance delivery methods mentioned earlier, the USAID Health Program is putting in place a direct financing mechanism based on a FARA (Fixed Amount Reimbursement Agreement) type contractual instrument at the central level. The H2S Component has begun discussions in this regard with DAGE/MOH, responsible for overseeing PBF activities. DAGE has opened accounts to lodge PBF funds and so have beneficiaries who will be receiving wire transfers. The process was however delayed due to changes in the management of DAGE. The H2S Component continues to advocate for the signing of this FARA.

Box A3b: Implementation of the PBF pilot phase – Lessons learned in Year 1

Project bodies at the central level include the steering committee, the technical and management committee and the BAP. They are represented at the regional level by the regional management committee (CRG).

- **The steering committee, chaired by the SG**, is composed of EIPS members and representatives of the MEF and local government units. The EIPS, established in 2006, provides advisory support to the Ministry of Health on all issues relating to policy design as well as policy implementation. However, the low frequency of meetings (two statutory meetings per year) and the lack of involvement in the implementation process are drawbacks for a pilot activity such as the PBF pilot phase which requires closer monitoring. Key events such as receiving guidance from the new Minister and her cabinet, launching the project at the national level and convening the resource mobilization meeting with TFPs are yet to be organized.
- **The CTGP** is composed of representatives of the different MOH departments and services and TFPs who participate in all stages of the process and hence facilitates the exchange of information. The coordinator of the BAP is a member of the CTGP and the BAP serves as the secretariat. Placing these two bodies under the authority of two different departments has created uncertainty as to the role each of these departments will play in the PBF process and is an obstacle for decision-making and project implementation.
- **The CRG** monitors the pilot project's activities at the regional level. To ensure successful PBF implementation, activities must be closely supervised by this body and a capacity-building program implemented for its members.
- **Commitment** and interactions with beneficiaries. The project's institutional framework was based on the principled commitment of social partners to the PBF process as well as the commitment of stakeholders to the principles of the project. Field visits noted the adoption by providers of new behaviors as they now pay greater attention to quality. Furthermore, providers now focus on reaching precise quarterly objectives and this can, in the short term, increase the levels of PBF-related indicators. This commitment was however clouded by the observance of health workers of the decision issued by their respective labor unions to withhold health-related information. In other words, it will be difficult to achieve PBF expected results without resolving issues raised by labor unions in the health sector.

The MOH, through the CTGP, requested the assistance of the H2S Component to develop a PBF application including a website and a data management system. Broad Branch prepared a strategy paper in this regard. The paper was validated by the CTGP and an initial assistance mission organized with Broad Branch. The objective of this mission was to identify needs, discuss the conditions

necessary for the development of the application, recruit a local developer and prepare an action plan in collaboration with the BAP. During this mission, working sessions were held with the IT Unit of the MOH and the National Healthcare Information Service (SNIS).

Other achievements. The PBF pilot project being supported by USAID was discussed with the Minister of Health and Social Action and her cabinet members during her visit to the offices of the H2S Component. This was an opportunity to assess the level of implementation and especially discuss bottlenecks. Furthermore, meetings were held between ChildFund and H2S at national and regional levels in relation to the support provided by other components of the USAID Health Program to finance PBF bonuses. ChildFund's contribution will cover the payment of bonuses to community workers at health huts and rural maternities in pilot districts.

1.2.5. Challenges and solutions

The involvement of local government units in the coordination and sharing of information on health actions does not measure up to their responsibilities in the health sector as provided for under the institutional framework in support of the country's political and administrative decentralization system. The H2S Component is currently providing assistance to joint annual reviews and facilitating regional consultations on health, and these platforms offer possibilities to mobilize local governments. The H2S Component will rely on its partnership with regional development agencies to strengthen advocacy with mayors, chairs of rural councils, regional councils and health commissions in local government units and ensure that operational plans of local government units (POCL) and healthcare activates scheduled in their annual investment plans are incorporated into AWPs of districts and regions and that they actively participate in the coordination of health interventions at the regional and local level.

Performances in priority areas of the health sector are to be achieved in medical regions and health districts. However, the poor leadership skills and weak administrative and financial management capacities of these institutions are major setbacks for the implementation of PNDS strategic guidelines on health system governance and performance-based management, reforms in USAID assistance delivery modalities and the commitment to strengthen direct assistance to governmental and non-governmental organizations. To meet this challenge, the H2S Component is providing support to improve health governance, planning and monitoring of interventions at the regional and local levels as well as strengthen the capacities of RHMTs and DHMTs in administrative and financial management. Direct financing and PBF activities are supported by the Component to strengthen accountability of RHMTs and DHMTs and equip them with the tools and means necessary to enhance their capacities and motivate healthcare workers in health centers and health posts as well as community health workers. To back up these interventions, the H2S Component will ensure that health system governance is closely monitored and best practices shared. It will also help to enhance the leadership skills of regional and district health management teams. To this effect, training tools will be designed and a training program developed to enhance leadership skills in the Component's intervention regions.

The start of the first year of the PBF project's pilot phase met with a number of obstacles with regard to the satisfaction of prerequisites identified during the project design phase. Furthermore, DAGE/MOH was slow to take over the PBF process and this delayed the transfer of PBF funds to the MOH. Health data could not be easily obtained and beneficiaries signed their performance contracts behind schedule as a result of the delay in the resolution of labor union strikes and their decision to withhold information. Finally, back up measures (equipment, proper supply of medicines and

essential products, logistical means...), in respect of which certain technical and financial partners had made commitments to provide assistance, are yet to be effective. The H2S Component will continue to advocate with the MOH for concrete measures to be taken to remove these bottlenecks.

1.2.6. Lessons learned

- Collaboration with central services of the MOH (DAGE, CAFSP, CAS/PNDS) is a necessary condition for making rapid progress in the development and ownership of new management and planning systems and tools and for their involvement at the regional and local levels: the training guide on health system governance, the ORCAP tool and the administrative and financial management system of medical regions and health districts are perfect illustrations.
- Beneficiaries should be effectively involved in the definition of PBF indicators to avoid redefining certain performance indicators, whose method of calculation is open to various interpretations (TB patients treated at health posts for instance).
- The level of commitment of healthcare providers suggests that they are aware of the positive impact PBF can have on healthcare facilities and on the quality of care. PBF will help to ensure greater accountability of chief nursing officers at health posts, equip them with instruments to better measure and enhance their performance and provide them with resources to motivate community health workers, community relays and the *Bajénnu Gokh* under their supervision.
- Capacities of medical regions should be strengthened to provide, in regions where PBF will be extended, the type of close support that regional bureaus of the USAID Health Program are providing for PBF implementation (which was commended by MOH authorities)
- See Box A3b

1.3. Sub-Component B: Social financing mechanisms

1.3.1. Expected results and milestones for Year 1

The following table recaps milestones set for this sub-component to track progress towards achieving expected results for Year 1 of the H2S Component. By achieving its results (RB1, RB2 and RB3) under the "social financing mechanisms" sub-component, the H2S Component will contribute to reaching the USAID Health Program's Intermediate Result 3.2 on "improved health system performance through development and implementation of national level policies", particularly the "access" dimension of this IR. The three expected results will indeed contribute to improving financial access to healthcare for populations in general and vulnerable groups in particular, by reducing financial barriers to healthcare and expanding health insurance coverage through mutual health insurance schemes and the support of government authorities.

Expected results of the H2S Component	Milestones for Year 1
R.B.1: Setting up of a favorable framework to improve financial access to health care supported by risk-pooling mechanisms	• A legal framework for the implementation of the test phase of the DECAM project is put in place (opinion of CTAJ required) • Technical and financial feasibility study on the National Solidarity Fund for Healthcare (FNSS) is conducted and validated • Templates for MHO financial reports and technical reports are developed
R.B2: Significant increase in health insurance coverage through strengthened local networks and sustainable MHOs	• A feasibility study on the DECAM project's network of MHOs at the departmental level is conducted • MHOs are operational in all local government units in three (3) departments (Kolda, Louga and Kaolack) • A risk-pooling mechanism is developed to share large risks and professionalize risk-management in each of the three (3) departments • Existing federations of MHOs implement their communication plans
R.B3: Increased access of vulnerable groups to healthcare through MHOs	• A mid-term review of the PLWHA support project in the Kaolack region is conducted • Health insurance, through MHOs, is effectively provided to vulnerable groups in at least twenty (20) MHOs

During the H2S Component's first implementation year, accomplishments under the "social financing mechanisms" sub-component helped to progress, at varying degrees, towards expected results. The finalization of draft decrees on the creation of the National solidarity fund for healthcare (FNSS), the National guarantee fund and the Administrative authority on social mutual assistance as well as the establishment of a platform for the harmonization of implementation mechanisms of the project to extend health insurance coverage within a decentralization context (DECAM project) are key stages towards building an environment likely to improve financial access to healthcare. Furthermore, support has begun to enhance the capacities of local MHO networks in supporting the extension of health insurance coverage with the convening of meetings of departmental development committees (CDD) to mark the start of the DECAM project in the focus departments of Kaolack, Kolda and Louga, the conduct of a feasibility study on an MHO departmental network in each focus department under the DECAM project, the creation of new MHOs and the restructuring of existing MHOs in pilot departments of the DECAM project. Finally, the mid-term evaluation of the PLWHA pilot project in the Kaolack region generated an information base and identified lessons that the H2S Component and its partners can build on to further increase health insurance coverage for vulnerable groups through MHOs. Accomplishments, challenges and lessons learned are presented hereafter under the three activity areas of the sub-component: (i) support frameworks for social financing mechanisms, (ii) management capacities of networks and MHOs, and (iii) protection of vulnerable groups.

1.3.2. Favorable support frameworks

Finalization of draft decrees on the creation of the National Solidarity Fund for Healthcare (FNSS), the National Guarantee Fund and the Administrative Authority on Social Mutual Assistance. The Component assisted the Ministry of Health and Social Action in the preparation of draft decrees on the organization and operation of the National Office on Social Mutual organizations (ONAMS), the Guarantee Fund (FG) for social mutual assistance and the National Solidarity Fund for Healthcare (FNSS) by making available the services of a legal expert, financing a workshop to draft the decrees and participating in the validation process. The workshop to draft the decrees was

held in April 2012 and was attended by members of the select technical committee comprising senior officers of CAFSP and of IAAF/MOH, representatives of mutual health organizations, the Ministry of Economy and Finance and technical and financial partners (Abt, WHO, UEMOA). The objectives of the workshop were to discuss general guidelines on the structure and operation of the said organs and to find possible points of synergy between these three institutional frameworks. The draft decrees prepared during this workshop were validated at a meeting held in May 2012 at the MOH under the chairmanship of the *Directeur de Cabinet* and with the participation of the General Delegate for National Solidarity and Social Protection.

The adoption of these drafts will contribute to building a favorable framework to improve financial access to healthcare through MHOs. The legal status adopted for these institutions is that of an industrial and commercial public establishment in compliance with the directives of the UEMOA community regulations and the provisions of the Senegalese legal framework in this regard. The subsequent adoption of these draft texts will contribute to strengthening financial support mechanisms (FNSS) and regulatory mechanisms (ONAMS, FNG) of MHOs in Senegal. It will also be an important signal of the political will of the newly elected Senegalese authorities to extend health coverage to people in the informal sector and in rural areas through MHOs. See **Box B1** on current trends in health insurance coverage in Senegal.

Box B1: Current trends in health insurance coverage in Senegal

Accessible healthcare remains a major challenge for the health sector in Senegal as a result of the low purchasing power of most segments of the population and the low level of social health protection. On the whole, social security in Senegal is quite limited: less than 20% of the population benefits from social protection and those covered are mainly private and public sector workers and their families. To cope with the dual challenge of providing Senegalese with financial access to and financial protection in healthcare, the country developed in 2008 a national strategy on the expansion of health insurance coverage. Combined with the consensus reached on expansion strategies, recent developments in the area of health insurance coverage are opening a window of opportunity to indeed accelerate the expansion of health insurance coverage at the country level. These include the UEMOA regulatory framework and the project for universal health coverage championed by the new political authorities.

Establishment of the UEMOA regulatory framework. The Council of Ministers of UEMOA adopted Regulation 07/2009/CM/UEMOA on 26 June 2009 in an effort to promote social mutual organizations in member countries. The purpose of this regulation is to put in place a standard, transparent and effective regulatory framework that will ensure the healthy promotion of social mutual assistance in UEMOA countries. The UEMOA regulation provides for the establishment, in each member country, of an administrative authority governing social mutual assistance schemes as well as a guarantee fund to help support schemes in difficulty. Furthermore, the community regulation offers social schemes the possibility of covering other social risks for beneficiaries albeit health insurance remains the chief purpose.

Universal Health Coverage: A Presidential Initiative. After the change of government which occurred in March 2012, the newly elected President of the Republic and the authorities of Senegal identified government priorities including the extension of social protection in general and universal health coverage in particular. This political determination is reflected in the structure of the new government with the establishment of a General Delegation for Social Protection and National Solidarity and the future creation of an independent fund for universal social protection (*Caisse Autonome de Protection Sociale Universelle* – CAPSU) whose resources will be primarily earmarked for health insurance coverage of vulnerable groups.

Establishment of a platform to support the harmonization of implementation mechanisms of the project on the extension of health insurance coverage within a decentralization context (DECAM project). The Component co-financed with the Belgian Technical Cooperation and WHO the organization of a workshop to harmonize implementation mechanisms of the DECAM project's pilot phase in February 2012. It was attended by representatives of MHO regional federations, ARDs, the UAEL, technical and financial partners (WHO, Abt, PAMAS), medical regions and the Ministry of Economy and Finance. The objectives were to discuss intervention areas of DECAM as indicated in the project document; discuss the guiding principles of the National Solidarity Fund for Healthcare;

validate the approach for the establishment of MHOs and MHO networks; define the roles of the various actors involved in the implementation of the DECAM project (local governments, administrative authorities, healthcare providers, MHOs and MHO networks); remodel management, monitoring/evaluation and communication tools of MHOs to fit the DECAM structure; and identify possible areas of collaboration between the Ministry of Health and TFPs on the one hand and among TFPs themselves on the other hand.

Recommendations were made on (i) the rules for the application of the UEMOA legal framework on social insurance schemes, (ii) strategies for linking FNSS missions with DECAM guidelines; (iii) the role of key stakeholders in the establishment of MHO networks at the departmental level; and (iv) measures to be taken for a better adaptation of management and communication tools to the DECAM structure. During this workshop, in which administrative authorities were highly involved, consensus was reached on the territorial approach for the establishment of MHOs and the constitution of networks at the departmental level. This is a significant step forward towards testing an MHO model in support of the expansion of health insurance coverage for the informal sector and rural populations in Senegal.

Other achievements. In light of the momentum created for the harmonization of the DECAM project's implementation mechanisms, the Ministry of Health and Social Action established a select technical committee in charge of monitoring implementation of recommendations issued at the harmonization workshop. The committee is composed of CAFSP, WHO, BTC, Abt/USAID and the World Bank. It convenes every quarter to track progress of the DECAM project in pilot departments.

Difficulties encountered on the road to reaching milestones. Implementation of the feasibility study on the National Solidarity Fund for Healthcare was delayed because the tender process was restarted in compliance with the provisions of the public procurement code of Senegal. All necessary formalities have now been accomplished: the call for tender has been published in newspapers and the process to recruit the firm in charge of conducting the study is underway.

The development of templates for financial and technical reports of MHOs was to be preceded by a workshop on the adaptation of these tools to the context of the DECAM project and this workshop was to be attended by new stakeholders such as local government units to ensure coverage for indigents and the establishment of favorable frameworks (FNSS). However, contacts have been established with firms specializing in the development of management tools so as to fast-track the process.

1.3.3. Management capacities of networks and MHOs.

Meetings of departmental development committees held to mark the start of DECAM project implementation in the focus departments of Kaolack, Kolda and Louga. The three pilot departments of Kaolack, Kolda and Louga held their CDD meetings to launch the DECAM project between the months of May and June 2012. The objectives of these meetings were to present the guidelines of the DECAM project so as to encourage ownership by local actors, and to assess the situation of health insurance coverage through MHOs in the department. They were chaired by the *préfet* of the department and attended by *sous-préfets*, mayors of communes, presidents of rural councils, heads of departmental services, MHO managers, representatives of development partners and civil society.

The outcome of CDD meetings serves as a platform for the establishment of the DECAM project in the three pilot departments. Recommendations were made for key stakeholders, particularly local

governments, to support implementation of the project. Local government units should therefore not only garner support from their partners for the development of MHOs, but also initiate meetings of their councils to discuss and include budgetary support for MHOs to ensure the protection of the indigent. Advocacy must be conducted at all levels for the setting up of the equity fund to help the most vulnerable groups. MHO managers should, for their part, significantly improve communication efforts to ensure ownership of MHOs by the populations. At the end of each CDD meeting, a DECAM monitoring committee at the department level (CDS) was established by order of the *Préfet*.

These committees are chaired by the *préfets* and include representatives of all stakeholders involved in the implementation of the DECAM project. Lastly, following these CDD meetings, local development committees (CLD) also met in the three pilot departments. They were attended by administrative authorities, technical services, local government units, healthcare providers, MHOs and community-based organizations. Presidents of rural councils made commitments to provide financial and other support to MHOs in their areas.

A feasibility study on the DECAM project's departmental network of MHOs is conducted in each focus department. The start of the pilot phase of the DECAM project is backed by the conduct of a feasibility study in all four pilot departments to help facilitate the process of adapting the design of MHOs. The general objective of the feasibility study is to provide social, economic, institutional and health information for the implementation of the DECAM pilot phase. The specific objectives include: (i) compiling general information on the demographic, economic and social situation, financial institutions and household income sources and levels in pilot departments; (ii) compiling general information on the availability and delivery of healthcare services in pilot departments; (iii) analyzing the level and patterns of health service use as well as healthcare spending using existing data sources; (iv) assessing the level of functionality of existing MHOs in pilot departments; and (v) developing scenarios of harmonized basic MHO parameters and of departmental networks tailored to socio-economic and health environments in pilot departments.

The feasibility study was conducted in each department with the support of the Regional Development Agency (ARD), the regional federation of MHOs and the MHO focal point in health districts concerned. Results of the feasibility study were presented to CDS members of the DECAM project during the month of September 2012: see Box B2 summarizing the key results presented to CDS members in support of discussions and consensus on MHO parameters. These presentations allowed stakeholders at the departmental level to validate technical design parameters, the MHO setting up/restructuring approach as well as the networking approach.

Establishment of new MHOs and restructuring of existing MHOs initiated. As part of their support for the implementation of the DECAM project's pilot phase, the three regional bureaus of Kaolack, Kolda and Louga embarked on the process of establishing/restructuring MHOs. They thus helped to set up action committees in local government units where there were no MHOs and provide committee members with training on the basic concepts of an MHO and on the setting up process. Eight MHO action committees were set up in the Department of Louga, nine in Kolda and six in Kaolack. Meetings were organized in each local government unit. The objectives of these events were to present the DECAM project to all resource persons in targeted local government units, legitimize the mandates of the said committees and finally encourage ownership of the project by communities.

Box B2: Key results of the feasibility study on MHO networks under the DECAM project

Results of the four feasibility studies on MHO departmental networks included significant information for enhancing the development and harmonization of benefits packages, membership contribution policies and subsidization policies under the DECAM project being implemented in the pilot departments of Kaolack, Kolda, Louga and St. Louis. Key results focused on the ability of households to pay and the affordability of benefits package options.

Household income inequalities between and within pilot departments are reflective of inequalities in Senegal. The department of St. Louis is among the five departments in the country with the highest levels of income where average annual spending per household is greater than 300,000 CFA francs. The department of Kaolack is part of the intermediary group of departments where average annual spending per household is approximately 200,000 CFA francs. The departments of Louga and Kolda are among the fifteen poorest departments in the country: average annual spending per household is 160,000 CFA francs and 135,000 CFA francs respectively. Besides, annual healthcare expenditures of households are significant in pilot departments. They rose to 2.4 billion CFA francs in the department of Kaolack in 2005/2006, 1.9 billion in the department of St. Louis, 1.1 billion in the department of Kolda and 656 million in the department of Louga. Consequently, the recycling of direct household spending through prepayment mechanisms could serve as a basis for MHO contribution.

The attractiveness of benefits packages can be improved by extending coverage to include hospital care, specialty drugs, the services of private providers and increasing the amount paid by MHOs in order to reduce co-payments by beneficiaries. Benefits package options are designed to improve access to priority healthcare services including maternal health services, family planning services, child health services and services to protect households against catastrophic healthcare spending. Under a status quo whereby the Government is not subsidizing MHOs, the cost of benefits packages will range between 6,500 and 8,000 CFA francs per beneficiary and per year and this can only be afforded by half of households with the highest levels of income in pilot departments. A 50% subsidization of MHO premium payments costing the government between 3,500 and 4,000 CFA francs per beneficiary and per year would guarantee the affordability of health insurance for the majority of the population. It should however be coupled with targeted subsidy for the poorest to ensure health protection for indigents.

A total of four hundred and ninety three (493) MHO action committee members were trained in local government units within focus departments: 180 in Kolda, 136 in Kaolack and 177 in Louga. The purpose of the training program on the basic concepts of an MHO is to enhance the capacities of participants to effectively conduct the MHO setting up process. The specific objective is to equip action committee members with the necessary skills enabling them to conduct the MHO setting up process from the onset up to the preparation and organization of the initial general assembly meeting. Training was conducted in group or concurrent sessions depending on the geographical or demographic features of the department. In addition to action committee members, presidents of rural councils and chief nursing officers at health posts also participated in these workshops. On average, about twenty individuals per action committee benefited from these training activities.

The regional bureaus of Kaolack, Kolda and Louga continued their support to strengthen existing MHOs and MHO networks in other intervention zones of the Component.

Difficulties encountered on the road to reaching milestones. The delay in the implementation process of DECAM's pilot phase did not make it possible to set up departmental federations which were to manage risk pools and ensure MHOs were run in a professional manner in each of the three (3) focus departments. This activity will be conducted during the second year.

1.3.4. Protection of vulnerable groups

Mid-term evaluation of the PLWHA support project in the Kaolack region conducted. The pilot project implemented in the Kaolack region was designed to enhance self-management capacities and improve the accountability of PLWHAs as part of efforts to provide them with medical and socio-economic support. It is implemented by the Ministry of Health through DLSI with the technical and

financial support of the USAID Health Program (FHI and Abt Associates) and other actors working in the field of HIV/AIDS. Two courses of action were defined to enhance the capacities of PLWHA and hence enable them to take care of their socio-economic needs: (i) subsidizing healthcare for PLWHAs to improve access to healthcare, and (ii) facilitating access to loans for income-generating activities and thereby increasing income levels of PLWHAs. A social guarantee fund (FGS) was established to mitigate risks taken by decentralized financing systems and MHOs in their mission to lend money to PLWHAs and manage healthcare consumption respectively.

Prior to the evaluation of the project, a mission jointly conducted by H2S and FHI360 visited Kaolack in February 2012. During this mission, the team met with key project actors (local administrative authorities, MECUDEF officials, the Chair of the regional federation of MHOs in Kaolack, members of the PLWHA association Bokk Lepp, and heads of the project management unit). This mission, using a participatory approach, enabled: (i) the definition of evaluation objectives, perspective, scope and key areas, (ii) the identification of evaluation questions, and (iii) the preparation of the first draft of the terms of reference.

The evaluation was conducted by a team of consultants under the coordination of FHI360 and Abt (see **Box B3**). The evaluation report made recommendations on: (i) the project's institutional framework, (ii) the implementation plan, (iii) medical coverage through MHOs and regional MHO federations, (iv) loans through savings and credit unions, and (v) the role of PLWHA associations in the implementation of the project. A technical meeting, attended by all those involved in the implementation of the project, was organized in Kaolack to validate these recommendations in July 2012. Implementation of these recommendations will help to consolidate accomplishments of the project in the Kaolack region and make possible its extension to other regions within the country.

Protection of other vulnerable groups. Regional bureaus reinforced their support to other initiatives regarding the protection of vulnerable groups. The Component assists the mechanism which provides support to poor people in the commune of Louga targeting **1,100 beneficiaries**. It also provides assistance to schemes offering health protection to Koranic school pupils (*talibés*) in the Thiès region: the MHO for *talibés* in the commune of Thiès covers about thirty (30) Koranic schools which have enrolled 800 *talibés*. In August 2012, **premium payments for 450 talibés were paid in full**. Lastly, the Component continued to support sponsorship of children living in difficult conditions through MHOs in the Kolda region in collaboration with the NGO World Vision: **21,718 children were sponsored by World Vision through MHOs in 2012.**

Box B3: PLWHA support project - Main findings of the evaluation

The operational objectives for fiscal year 2010-2011 to be achieved by June 2011 were to ensure the enrolment of 100 PLWHAs in MHOs and grant 25 loans for projects or income-generating activities. These objectives were set on the basis of the initial funding of 35 million CFA francs provided by FHI360 and Abt Associates under the previous health program (2006-2011).

For the "medical support" component, a total of 152 members and 317 beneficiaries were recorded, though there was a relative decline in the number of members between 2011 and 2012. Regarding premium payments, 120 beneficiaries had paid their premiums in full in February 2012. Despite this situation, providing medical support to PLWHAs has generally proved to function well. From April 2011 to March 2012, the project recorded 170 medical cases for a total cost of 1,375,840 CFA francs. The social guarantee fund covered 51% of these costs, PLWHAs contributed 24% and MHOs 25%.

The economic component, because of the low level of FGS funding, was only focused on the department of Kaolack where 33 loans were granted to carry out income-generating activities. These were short-term loans and amounted to a total of 7,750,000 CFA francs. The project provided security covering 50% of the loans, i.e. 3,875,000 CFA francs. They were customized economic development projects and related mostly to agriculture, trade and services. The minimum loan granted to PLWHAs was 50,000 CFA francs and the maximum 300,000 CFA francs. A good performance was noted in the repayment of loans during the first few months. However, the situation gradually worsened over the months and by the end of April 2012 only 6 loans had been fully repaid. There are about twenty (20) loans in the outstanding loan portfolio. Factors behind this counter-performance can be found both on the side of the project (the system) as well as on the side of beneficiaries themselves. The MFI disbursing the loans has however indicated that there is no significant difference between beneficiaries of the project and its other clients with regard to the trend in loan repayments.

In general, beneficiaries positively welcomed the actions undertaken by the project, which they believe effectively address their needs and contribute to reducing the financial barrier to accessing healthcare. Furthermore, other actors at the regional level recognize the relevance of the project and the need for it to continue in Kaolack and in other regions within the country. However, corrective measures must be taken with the assistance of all stakeholders in order to put the project on a more sustainable footing.

Other achievements. The Component provided technical support for the design and establishment of the Equity fund for the protection of indigents through MHOs. The Equity fund is an initiative of the Belgian Technical Cooperation under the PAMAS project. Its purpose is to improve the affordability of healthcare and social protection of households through MHOs in the Diourbel, Fatick, Kaolack and Kaffrine regions. The number of beneficiaries targeted in the four regions is estimated at 7,294 (indigents and vulnerable groups). Given that the BTC and the H2S Component have four focus regions in common, it was strongly suggested to build areas of synergy and explore the possibility of using the equity fund as an instrument to support DECAM implementation pending the establishment of the national solidarity fund for healthcare. The ceremony to launch the PAMAS equity fund was held and an order signed by the Governor of Kaolack establishing the regional monitoring committee. The committee will, inter alia, serve as an interface between CAFSP and local monitoring committees of the equity fund, ensure compliance with the operations manual, validate the list of indigents, and participate in the evaluation of the equity fund through supervision and control.

1.3.5. Challenges and solutions

The institutional instability at CAFSP is a major challenge in the coordination of MHO development actions, the orientation and monitoring of pilot tests to expand health insurance coverage. In less than a year, CAFSP has had three (3) coordinators and despite the creation of the CACMU (Support unit for universal health coverage) several months ago, its coordinator is yet to be officially appointed to our knowledge. It is therefore difficult to identify the path that the MOH will take to extend health coverage or the MOH officials with whom to engage in order to ensure their support to MHOs. To address these challenges, the H2S Component will continue to advocate with MOH officials for a stable institutional framework to support the development of MHOs.

The inability to mobilize government resources to finance MHO contributions due to the lack of a budget line to this effect is a major challenge in the implementation of the pilot phase of the DECAM project. The H2S Component constantly drew the attention of the MOH to the need for transitional measures such as voting a budget to support MHOs pending the establishment of the FNSS or other financial mechanisms to boost the expansion of health insurance coverage and hence the start of the DECAM pilot phase. The H2S Component was informed that this would be difficult for the 2012 budget but funds will be included in the 2013 budget. The H2S Component had planned to extend its support under the DECAM project to three new departments during Year 2 but is now compelled to delay this extension pending the adoption of these measures by the MOH. The H2S Component will continue to advocate with MOH authorities for the adoption of transitional measures.

1.3.6. Lessons learned

- The political commitment of the new authorities to promote universal health coverage is creating an enabling environment for the development of MHOs and contributing to redirecting the interventions of technical and financial partners towards the health protection sector.

- The involvement of locally-based administrative authorities (*préfets* and *sous-préfets*) facilitated the mobilization of all key local actors in the implementation of the pilot phase of DECAM.

- The empowerment of local governments and healthcare providers in the implementation of the DECAM project is helping them have a clearer understanding of their roles and responsibilities in the development of MHOs and the expansion of health coverage.

1.4. Sub-Component C: National level health policies and systems

1.4.1. Expected results and milestones for Year 1

Expected results under the sub-component "National level health polices and systems" are described in the table below. Interventions under this sub-component contribute to the realization of Intermediate Result 3.2 (Improved health system performance through development and implementation of national level policies) of USAID/Senegal's Health Program by strengthening capacities in developing health policies and improving resource allocation to support PNDS implementation.

Expected results of the H2S Component	Milestones for Year 1
R.C1: Enhanced capacities to develop, implement and monitor health policies	• The Health Policy Initiatives Group (EIPS) of the MOH holds its statutory meetings as scheduled • A national community health policy is developed • A procedures manual for the national medical store (PNA) is developed • A technical group on health systems strengthening is functional under the supervision of the EIPS
R.C2: Allocation of greater resources for healthcare spending to support and implement PNDS priorities	• The 2006-2008 National Health Accounts (NHA) are finalized • The 2012-2014 MTEF for health is prepared within the required time-limit • The performance report of the 2011 MTEF for the health sector is delivered within the required time-limit • A technical group on resource allocation criteria is established to work under the EIPS • A technical group on budget arbitration and monitoring mechanisms is established

Achievements have facilitated progress towards the attainment of expected results under this sub-component. The of the first year regular holding of meetings of the EIPS, the development of a community health policy by the EIPS, the establishment of a "Health Systems Strengthening" platform, and building the capacities of the PNA are all part of efforts to enhance health policy development and implementation capacities. Furthermore, key stages have been completed to improve allocation of healthcare resources and PNDS implementation. These include the production of the 2011 MTEF/Health performance report, the preparation of the 2012-2014 MTEF/Health and the preliminary 2013-2015 MTEF/Health as well as the commitment of the Directorate of General Administration and Equipment of the MOH to improve resource allocation and budget arbitration and monitoring.

Finally, there was a significant addition to expectations set out for the H2S Component during the year by USAID, which mandated the Component to provide the MOH with support for the organization of national consultations on health and social action: a highly strategic activity that was not planned but called for the mobilization of significant resources by the Component. Achievements of this sub-component are presented under its two activity areas: (i) policies and reforms, and (ii) monitoring of the PNDS.

1.4.2. Policies and reforms

Statutory meetings of the EIPS held. The Health Policy Initiatives Group (EIPS) continued to play its advisory role to the Minister on issues relating to policy design and strategic orientations in the health sector. Two (2) statutory meetings of the EIPS were held during FY 2012. The first meeting, held on 25 January 2012, reviewed the state of progress of the performance-based financing pilot project and decided on issues that the EIPS will be dealing with in 2012. It was subsequent to this meeting that key decisions were made regarding the start of the PBF project and the organization of an orientation session on PBF for EIPS members. Furthermore, the H2S Component successfully advocated for the EIPS to include on its annual agenda the development of a community health policy and the establishment of an HSS platform. The second meeting held on 31 May 2012 focused on the reorganization of the MTEF/Health: health insurance was hence moved from the governance program to the HSS program.

The H2S Component, in addition to providing assistance for the organization of the EIPS' statutory meetings, also helped to enhance the capacities of its members through two training activities. Firstly, the Component financed the training of EIPS members and other MOH central-level officials on health policy formulation and implementation: a total of sixty (60) participants attended this session organized with the technical support of Group ISSA. Using on-going reforms in the sector such as the MTEF and PBF as examples, participants were able to gain a better understanding of health policy and reform formulation, implementation and monitoring processes. The H2S Component in collaboration with the technical and management committee of the PBF project then organized an orientation workshop on PBF for EIPS members. Emphasis was placed on the content and challenges of this reform project which introduces a health financing mechanism that is best suited to the context of performance-based management.

Community health policy launched by the EIPS. The H2S Component, in collaboration with the Community Health Component of the USAID Health Program implemented by ChildFund, is assisting the MOH in the development of a community health policy. The MOH issued an office memo (nr. 000441MSHP/DS/DSSP) dated 3 January 2012 creating an EIPS working group in charge of this initiative. The H2S co-financed with ChildFund a study on the status of community health in Senegal. During the follow-up meeting held at the end of September 2012, information was shared that the data collection phase had been completed and that data processing and analysis was underway: a first draft of the summary of results is available. The establishment of this baseline situation is the first phase identified by the MOH prior to work by the following four (4) thematic sub-groups:

- Sub-group 1 – Institutional framework: Linkage between health system levels, roles and responsibilities, norms
- Sub-group 2 – Intervention areas: scope, level of intervention, services package, profile
- Sub-group 3 - Motivation: type, source, sustainability
- Sub-group 4 – Financing: financing mechanisms, allocation criteria, sources

Procurement procedures manual for the National Medical Store (PNA) and setting up of its information and management system. The H2S Component focused the greater part of its support to reviewing the state of the PNA as regards supply management and the functionality of its drug supply information system. More specifically, the H2S Component provided technical support through

PATH to recruit two consulting firms for the development of the PNA's procurement procedures manual (DMA consulting firm) and management and information system (SENINFOR consulting firm). Work is in progress for both assignments. However, the timeframe initially set for the submission of final reports (end of September and end of October respectively) can no longer be adhered to for several reasons relating to the instability of the PNA.

Both firms completed certain stages of their respective missions. DMA completed the following stages: debriefing on and validation of the methodological approach by PNA; designation of a focal point; organizational pre-assessment; analysis of bottlenecks in the supply chain; review of tender documents prepared by PNA between 2007 and 2012; review of procurement procedures; review of procurement procedures of peripheral health facilities. The next stages to be implemented by DMA include: SWOT analysis of PNA's organizational system and procurement procedures; development of the procurement handbook. SENINFOR met with PNA in September to discuss its methodology and action plan. Another meeting is scheduled during the week of 15 October 2012 to discuss the new dates proposed and commence the evaluation process.

Furthermore, the H2S Component participated in several meetings initiated by the MOH and USAID on the frequent stock-out of drugs observed at service delivery points. The magnitude of these stock-outs has led USAID to reconsider its interventions in the area of drug supply. It emerged that support should be provided for the expansion (or even scaling up) of the Optimize project being implemented in the region of Saint Louis and whose strategy is based on mobile medical stores. Distribution is channeled through regional medical stores (PRA) and reaches down to the level of health posts.

In an effort to support this scaling up initiative (PAGE), the MOH issued an office memo (nr. 007235 dated 31 August 2012) setting up a PAGE support group. This group is chaired by the *Directeur de Cabinet* of the MOH. Its members include representatives of all departments within the MOH, the PNA and TFPs including USAID and the H2S Component. The mandate of the PAGE support group is to: (i) identify anchor points of the PAGE project within the framework of HSS; (ii) develop the Supply Chain Vision (VISAF 2020); (iii) finalize the PAGE strategic plan; and (iv) provide support for the implementation of PAGE and VISAF after they have been validated by the EIPS.

The H2S Component remains open to propositions from USAID and is ready to step up its interventions in the area of medicines. In this regard, PATH is currently working on extending the Optimize project to the regions of Louga, Matam, Diourbel, Kaolack and Fatick but in the form of regional distribution hubs covering 3 to 4 regions. This project will be submitted to the MOH and USAID shortly for comments and appropriate action.

"Health Systems Strengthening" platform. The initiative to establish a "Health systems strengthening" platform was taken by the former CAS/PNDS which has now become the Department of Planning, Research and Statistics (DPRS). Health sector TFPs participated in the first meeting of the HSS platform held at the WHO office. During this meeting, it was agreed that a mapping of HSS interventions was needed. This study was financed by WHO and the draft report is available. It will be shared shortly and the next stages determined. The report clearly shows that TFPs consider all of their interventions can be classified under HSS given the extensiveness of activities they believe to conduct within this framework and the significant amount of resources mobilized. This means that the platform should start by adopting a clear operational definition of the term HSS and give it specific content.

Other achievements. The Director of USAID/Senegal, in response to a request from the Minister of Health for support to on-going reforms designated the H2S Component to provide such assistance (USAID letter referenced AID/HEALTH 011/2012). It is on the basis of the above that the H2S Component is assisting the MOH prepare and organize national consultations on health and social action (**See Box C1**).

Box C1: National consultations on health and social action

National consultations on health and social action are being conducted in the context of a regime change and a shift in social policy orientations with greater attention paid to the issue of universal health coverage for Senegalese families. Measures were necessary to improve the delivery of services and health system governance following consensus on responses to numerous challenges regarding financial barriers to healthcare access. The objective of the national consultations on health and social action is to build national consensus on reforms to be undertaken in the health and social action sector to sustainably improve access to quality healthcare in a context of improved governance and performance-based management.

To achieve this objective, the MOH issued an office memo establishing the Steering committee in charge of preparing and organizing the national consultations. The Committee created five thematic groups to draft reports on issues entrusted to their responsibility and to propose solutions to fill possible gaps in the following thematic areas: (i) "Delivery of services"; (ii) "Social action services"; (iii) "Prevention"; (iv) "Universal health coverage"; and (v) "Health system governance". The Committee meets at least once a week during the preparatory phase to monitor the work of thematic groups, track the progress of activities and identify measures to address difficulties being faced by thematic groups. The Steering Committee will organize workshops to ensure thematic group reports are validated by all stakeholders. These reports will be summarized and will serve as a reference document to be used during national consultations.

Consultations are expected to have two outputs: (i) a general report on the national consultations and (ii) recommendations of national consultations. The general report will include a summary of thematic group findings validated and reviewed during consultations. The recommendations will summarize all measures proposed during consultations in relation to the five thematic areas and these will be submitted for the Government to conduct the relevant reforms. These deliverables are expected before December 2012.

The H2S Component provides technical and financial support to the MOH for the preparation and convening of these consultations. It helped draft the terms of reference of national consultation organs and recruited the consulting firm MGP Afrique to assist the Steering Committee in the monitoring of thematic group activities. The Abt national office houses the "Governance" group and the Abt team participates in the work of thematic groups.

Difficulties encountered on the road to reaching milestones. Difficulties encountered in the policy reform area mainly concern the PNA activity. In the early stages, PATH's scope of work as well as USAID's expectations had to be clarified because of a diverging viewpoint on the findings of the situational analysis of the PNA (study conducted by MSH). This situation greatly delayed the recruitment of the consulting firms in charge of developing the procurement procedures manual and the information system. Thereafter, changes in PNA management also slowed down the activities of these two studies. Work finally restarted but the initial deadlines cannot be met. It is however understood that Abt could step up its interventions in the near future.

1.4.3. Monitoring of the PNDS

2011 MTEF for health performance report produced. The 2011 performance report of the health sector's MTEF was produced with the financial support of the H2S Component. The H2S Component did indeed participate in the workshop to finalize this report but Group ISSA's assistance was not needed. The MTEF/Health group of the MOH now has sufficient capacity to successfully conduct the entire process of producing the performance report, which henceforth serves as a reference document for PNDS' annual joint portfolio reviews such as that conducted in July 2012.

The health sector's 2012-2014 MTEF and 2013-2015 preliminary MTEF delivered. The 2012-2014 MTEF/Health was consolidated and the 2013-2015 preliminary MTEF/Health produced within the required timeframe. The new structure of the MTEF/Health was adopted. The 2012-2015 MTEF/Health does not consider social action as a stand-alone program but rather integrates it into all components of the two programs, i.e. "Health systems strengthening" and "Health system governance". Similarly to the performance report, the H2S Component also financed the production of these documents. These two activities were conducted consecutively.

Directorate of General Administration and Equipment (DAGE) of the MOH has undertaken to improve resource allocation, budget arbitration, monitoring and execution. The resource allocation and budget arbitration and monitoring system is yet to be developed. However, advocacy efforts of the H2S Component and the queries of TFPs and the MEF on this issue during the JPR held on 16 and 17 July 2012 have finally persuaded DAGE to firmly commit to putting the system in place. To this effect, DAGE requested and obtained from H2S the addition of specific activities to its FY2013 action plan so as to set up the system.

Other achievements. The H2S Component provided technical and financial support for the organization of the PNDS 2012 joint supervision mission and JPR. The 2012 joint supervision mission visited the regions of Fatick and Kaolack which are in the intervention zone of the H2S Component. Among the themes selected was the provision of healthcare to PLWHAs through MHOs, an activity that the H2S Component supports in collaboration with FHI360.

The H2S Component, through Group ISSA, also provided the MOH with support to introduce the regional MTEF/Health in Kolda. Regional and district health management teams were provided guidance in this area by Group ISSA and are currently developing their first regional MTEF/Health. The regional MTEF/Health tools had to be initially developed at the central level, with the support of Group ISSA, including the annotated outline and procedures for its revision.

Difficulties encountered on the road to reaching milestones. The main difficulty encountered in the "PNDS monitoring" activity area concerns the 2006-2008 National Health Accounts. The H2S Component had made commitments to finance the reproduction and distribution of the final report. However, the report is yet to be finalized and funds have therefore not been mobilized. It is to be hoped that the enormous delay in the finalization of the 2006-2008 NHAs this year will prompt authorities to change their strategy. The H2S Component is advocating for the ANSD to lead the NHA activity given the shortage of capacity within the MOH.

1.4.4. Challenges and solutions

At the end of this first implementation year, it appears clearly that certain guidelines must be revised either because the context has changed or because there are new opportunities and hence new ambitions.

First, there is the issue of the availability of drugs: stock-outs and their causes were poorly evaluated. In addition to problems arising from procurement procedures, structural issues also explain stock-outs experienced at service delivery points. The preliminary findings of the consulting firm DMA provide an overview of the nature of these structural issues: (i) the PNA reform process was not properly completed; (ii) the respective roles of PRAs, medical regions and health districts in ensuring the availability of drugs are not clearly defined; (iii) expertise in the management of drugs is lacking at the operational level; and (iv) the increasingly free supply of drugs does not motivate health

facilitates for they have a tendency to show greater interest in drugs that are for sale. Consequently, an in-depth situational analysis on the availability drugs should be conducted to serve as a baseline and for the appropriate measures to be taken to sustainably reduce stock-outs.

The national consultations are an opportunity to assess bottlenecks that weigh down on the performance of the health system. Effective measures are particularly expected in the area of health system governance to strengthen leadership at the national and regional levels with the creation of the new regional departments of health and social action. The Component should pay close attention to these reform processes in order to provide the MOH with the relevant support for the implementation of the action plan that will emerge from the consultation process.

1.4.5. Lessons learned

- In an activity area as dynamic as health policy and reform, it is necessary to demonstrate flexibility and a considerable capacity for change in order to provide the MOH with meaningful support.

- A thorough assessment of the situation must be conducted if lasting solutions are to be found to address structural issues that affect an element of the health system as vital as drugs.

1.5.Sub-Component D: Coordination and Monitoring/Evaluation

1.5.1. Expected results and milestones for Year 1

Expected results and milestones for Year 1 of the sub-component "Coordination and Monitoring/Evaluation" are summarized in the table below. The H2S Component contributes to the realization of Intermediate Result 3.2 (Improved health system performance through development and implementation of national level policies) of USAID/Senegal's Health Program by ensuring coordinated implementation of the Program based on joint frameworks and support mechanisms (R.D1) and the functioning of monitoring frameworks and mechanisms (R.D2).

Expected results of the H2S Component	Milestones for Year 1
R.D1: Better coordinated approach to the implementation of the Health Program based on joint support frameworks and methods	• An inter-agency working group to share information, standardize practices (direct financing, per diem) and to handle coordination issues is operational • A consensus document on financial arrangements for a fair sharing of regional office costs adopted by implementing agencies of the Health Program • A manual describing common procedures, tools and reporting obligations for direct financing is adopted by all Health Program components • Four (4) inter-agency working groups focusing on themes relating to cross-cutting issues are established and operational
R.D2: Joint frameworks and mechanisms to monitor the Health Program are functional	• A monitoring and evaluation plan of the Component is developed • An action plan and a budget for FY2012 is prepared and approved • Progress reports of the Component are prepared and submitted within the required time-limits (quarterly and annual reports), • A baseline survey is conducted in the Program's geographic focus

Accomplishments under the sub-component "Coordination and Monitoring/Evaluation" during the first implementation year of the H2S Component enabled progress towards expected results. An inter-agency platform was set up to strengthen coordination of USAID Health Program interventions. An operations manual for the Health Program's regional bureaus and a per diem policy were jointly developed by implementing agencies. They reached consensus on cost-sharing arrangements for regional bureaus. Implementing agencies also prepared a guidance note on integrated planning and a concept paper on direct financing to better adapt USAID's assistance delivery methods to the regional and local levels. Moreover, the H2S Component's PMP was validated in collaboration with USAID. Finally, quarterly progress reports of the Component were submitted to USAID on time and the preliminary action plans for the period October 2012 to September 2013 as well as the FY2012 budget were also submitted to USAID.

1.5.2. Coordination

Setting up of an inter-agency platform to strengthen coordination of USAID Health Program interventions. Components of the USAID/Senegal Health Program have been working from the first quarter at putting in place instruments to ensure a coordinated approach to program activities. USAID/Senegal signed cooperating agreements with several agencies to implement the components of its Health Program. The USAID mission's health team expects these components to coordinate their work so as to create greater synergy and preserve the image of a single program before all beneficiaries. An inter-agency framework was established during the first quarter to ensure coordination of the USAID 2011-2016 Health Program. Inter-agency meetings focused on the

mandates of implementing agencies, areas of synergy between components and cost-sharing arrangements for the operation of regional bureaus.

Box D1: Inter-agency coordination framework of the Health Program

The implementing agencies of the Program (Abt, Intra Health, FHI360, Childfund and ADEMAS) met in November 2011 to share their technical proposals, first year action plans and identify areas of synergy. Four main areas of synergy were identified and working groups composed of representatives of all agencies established to prepare their scope of work and joint action plans. Guidelines were developed for the working groups:

- The "**Service delivery**" group was tasked with making proposals on the integrated package of services, the quality of services, the certification of matrons and the private sector.
- The "**Management and Coordination**" group is to come up with proposals for improved coordination in joint planning, management, information systems and monitoring and evaluation.
- The "**Health policy**" group was asked to reflect specifically on the community health policy during the first year of the Program.
- The "**Financing and sustainability**" group will work on issues relating to health protection for vulnerable persons, performance-based financing and direct financing.

The four groups defined their scope of action, developed their terms of reference, determined the schedule of their meetings and developed a work methodology. Several meetings were held during this first year to monitor and discuss activities of working groups. Workshops were also organized by some groups (service delivery and financing and sustainability) as well as the M&E committee. The following were developed during these activities jointly conducted by program components:

- A proposal on the package of services
- An operations manual for the Health Program's regional bureaus (see below)
- A per diem policy (see below)
- A guidance note on integrated planning (see Box D3 below)
- Establishment of a technical group for the development of a community health policy by the MOH
- A concept paper on direct financing (see Box A2c in section 1.2.3)

Components strived to maintain the flexibility and adaptability of the inter-agency coordination framework and hence cope with changes in the immediate environment of USAID/Senegal's Health Program. The "Health policy – community health" group became redundant after the establishment of a working group on the "community health policy" by the EIPS, which receives support from both the H2S Component and the Community Health Component of the Health Program. It was decided to refocus the scope of work of the inter-agency thematic group, and encourage components to actively participate in working groups established by the MOH. Furthermore, during the course of the year, components included on the agenda of the inter-agency coordination framework, the establishment of a "Communications" group to be led by ADEMAS. The latter implements the Health Program's "Health communication and promotion" component.

Regional bureaus actively participated in the work of inter-agency thematic groups. The Thiès regional bureau, taking advantage of its physical proximity to Dakar, participated in the activities of the "Management and Coordination" group, particularly the workshop to develop the PMP of the USAID Health Program. Besides, the Thiès regional bureau organized two workshops with administrative and financial officers of agencies to develop the operations manual of regional bureaus and the per diem policy. This participation allowed capitalization on the experiences and lessons learned by regional bureaus during the previous "Health Program".

Operations manual of the Health Program's regional bureaus and per diem policy jointly developed by agencies. Regional bureaus play a key role in the implementation of all components of the Health Program. Information on their installation, equipment and the recruitment of their staff is provided in **Section 1.1**. Results achieved by regional bureau teams are integrated into the reports of each component. All outputs under sub-components A and B, presented in **sections 1.2 and 1.3** are jointly produced by the national bureau and regional bureaus.

An operations manual was jointly developed by agencies to facilitate the organization and operation of regional bureaus. Several meetings were held by the "Coordination" committee of the inter-agency group on "Management and Coordination" during the development of this manual and prior to its submission to COPs for approval. Comments made by COPs were incorporated and a one-day meeting organized in Kaolack in July. Guidance was then provided to staff of regional bureaus on the utilization of this manual, which is also available at the national bureau.

Financial arrangements for a fair sharing of regional bureau costs adopted by implementing agencies of the Health Program. Investment costs relating to the refurbishment, equipment and acquisition of vehicles of the Health Program's regional bureaus are covered by the H2S Component implemented by Abt Associates. Staff costs and operating expenses of regional bureaus are shared among implementing agencies of the Health Program. **Box D2** provides a summary of regional bureau cost-sharing arrangements.

Guidance note on integrated planning finalized. So far, components of the USAID/Senegal Health Program have presented their activities and contributions to the program's results framework and PNDS implementation separately. Although regional bureaus have existed since the previous program, regional advisers participate in health planning processes at the local and regional levels with separate action plans for each component. To address this fragmented approach in the Health Program's interactions with partners at the central, regional and local levels, implementing agencies decided to develop an integrated planning framework at the Program level: see **Box D3** on the guidance note for integrated planning.

Box D2: Regional bureau cost-sharing arrangements

Health Program implementing agencies reached an agreement on the principles and terms of cost-sharing arrangements for the functioning of the three regional bureaus. In this regard, administrative and financial management staff of regional bureaus as well as administrative and finance officers of the various components met several times to exchange their experiences and harmonize practices. The availability of data on the operating expenses of regional bureaus and cost-sharing practices of the previous program helped save time to decide on cost-sharing options. An inter-agency meeting was held to review the results of the work conducted by administrative and financial officers of components. The meeting reached consensus on the principles and terms of this cost-sharing arrangement as follows:

- Abt, because of its mandate to ensure coordination of the USAID Health Program, will recruit and pay the salaries of the coordinators and office managers in all three regional bureaus;
- The salaries of secretaries and drivers will be divided among the three agencies (Intra Health, Childfund and FHI360), each paying a third;
- Operating expenses, excluding personnel costs, will be shared among the four agencies, each paying a fourth.

ADEMAS, the agency in charge of implementing the Health communication and promotion Component joined the four other agencies in 2012. Operating expenses, excluding personnel costs, will now be shared among the five (5) agencies, each paying a fifth.

Box D3: Guidance note on integrated planning

The Ministry of Health and Social Action (MOH) now has a planning system with a budget cycle compatible with the MTEF and MTEF/Health timeframes. Partners were associated in all activities that led to the setting up of this system. The challenge now is to consolidate the system by providing the MOH with effective support in the AWP development, implementation and monitoring process.

In this regard, Health Program components should enhance their participation in the Ministry's annual planning activity and present the indicative package of interventions they plan to jointly support. After approval and consolidation of this indicative package at the regional level, selected activities are included in AWPs of beneficiary facilities. All activities that are partially or fully funded by the different components make up the consolidated annual action plan of the USAID Health Program. The format of this action plan should facilitate understanding of interventions and their costs, component by component, and the identification of beneficiary health facilities being supported while ensuring that funded activities effectively contribute to the attainment of targets set for that year.

The development of this integrated plan will be much easier if action plans of components are prepared using the same format. The guidance note on integrated planning presents intervention areas and the organization of support to the regional planning process, the template for drafting annual action plans, describes the specific case of targeted services package for direct financing and defines the Health Program's planning cycle. The note was developed by the inter-agency working group on "Management and Coordination". This group met on several occasions and the first version of the note was submitted in May. It was discussed and amended prior to being submitted to USAID for validation.

1.5.3. Monitoring/Evaluation

PMP of the H2S Component validated with USAID. The PMP of the Component prepared this year was validated by USAID/Senegal. It includes sixteen (16) indicators and their definitions, calculation methods, the data needed for their calculation, a description of the data collection, transmission, processing and analysis process, templates for drafting periodic reports and their distribution route are all indicated. The PMP of the H2S Component is summarized in **Attachment 2**.

Quarterly reports of the Component submitted to USAID within the required time-limits. Quarterly reports and the annual report were submitted within the required time-limits with the contribution of regional bureaus, the administrative and finance officer and the various advisers. Each quarterly report presents the expected results of the component, milestones for Year 1 and activities conducted under each sub-component to reach these milestones, difficulties encountered, activities scheduled for the subsequent period and the financial situation. The annual report also includes information on outputs, the degree to which milestones have been reached, challenges and solutions, as well as lessons learned for each sub-component.

Preliminary action plan and budget for FY2012 prepared and submitted to USAID. The preliminary action plan and budget for FY2012 were prepared and submitted to USAID on time, i.e. before 1 September 2012. In this regard, the Component organized in August a planning workshop to identify, budget and select priority activities to be implemented during the Program's second year in collaboration with its partners at the Ministry of Health and Social Action. Beforehand, the level of implementation of the 2012 action plan was assessed at the end of the third quarter, the action plan for the fourth quarter prepared, guidelines and milestones for Year 2 determined as well as the 2013 annual action plan template.

Other achievements. The "Management and Coordination" inter-agency group established a committee on "Information systems and M&E" tasked during its first year with the design of a global PMP of the Health Program. A workshop was held and a draft PMP developed. It shall be finalized

during Year 2. Furthermore, a database on health districts covered by the Component was developed through data collection for monitoring indicators

1.5.4. Challenges and solutions

Major challenges in the areas of coordination and monitoring/evaluation are compatibility between schedules and the availability of information for monitoring. The Component managed to negotiate dates for the convening of inter-agency meetings whenever necessary. Emails were used extensively and effectively; working groups also operated in a similar manner. Regional bureaus took the necessary steps to participate in coordination meetings of medical regions and occasionally of health districts and hence facilitate the implementation of activities. The challenge concerning the availability of information was addressed through engagement with partners at the central and local levels. Support from regional bureaus to districts and MHO federations facilitated the availability of data. Relations between national advisers and staff at MOH central services also helped in obtaining information. The national bureau of the H2S Component and regional bureaus will hence consolidate their engagement with strategic and technical partners so as to facilitate the availability of information.

The H2S Component should keep a balance between coordination of Health Program interventions and coordination with other technical and financial partners working similar technical areas and in the same intervention regions. It put a lot of effort, during the first year, into coordinating with other Health Program components to the detriment of coordinating with other TFPs. The H2S Component has initiated discussions with the World Bank, WHO and the various projects of the Belgian Technical Cooperation to ensure coordination of interventions. It should pursue efforts to strengthen coordination frameworks with TFPs and if necessary formalize these through MOUs.

1.5.5. Lessons learned

- The participation of USAID's Health Team in activities of the Health Program's inter-agency group is an additional motivation for implementing agencies to coordinate their interventions and offers a platform for USAID to provide guidelines and state its expectations in relation to new initiatives jointly conducted by implementing agencies. Collaboration for the development of the direct financing mechanism is a perfect illustration.

- Collaboration with the different partners facilitates the exchange of information. Participation of regional bureaus in activities of medical regions and health districts makes it easy to obtain data for monitoring. Support to MHOs and MHO federations for the organization of their meetings and those of their Boards makes it possible to have up-to-date information.

2. Constraints

The annual action plan for Year 1 of the H2S Component was developed taking into consideration constraints relating to the political environment in 2012 and the introduction or extension of several additional planning, management and financing instruments that have not been validated for the most part. Given these constraints, the annual action plan for Year 1 of the H2S Component focused on the development and validation of planning, management and financing instruments to be jointly used by all components of the Health Program. Particular attention was given to activities that were less likely to be disrupted by the political environment in 2012: commencement of the PBF pilot phase in the three health districts, commencement of the DECAM pilot phase in the three departments.

Other specific constraints leading to the tardy implementation of the action plan for Year 1 include:

- The signing in October 2012 of the cooperative agreement resulted in an overlap of the start-up phase and the commencement of activities during the first quarter.

- The option to house regional bureaus in medical regions necessitated rehabilitation works on assigned buildings prior to the installation of the Health Program's regional teams.

- As a result of a slow recruitment process and renovation works at the Thiès and Kaolack regional bureaus, key personnel were not able to take up duties in a timely manner.

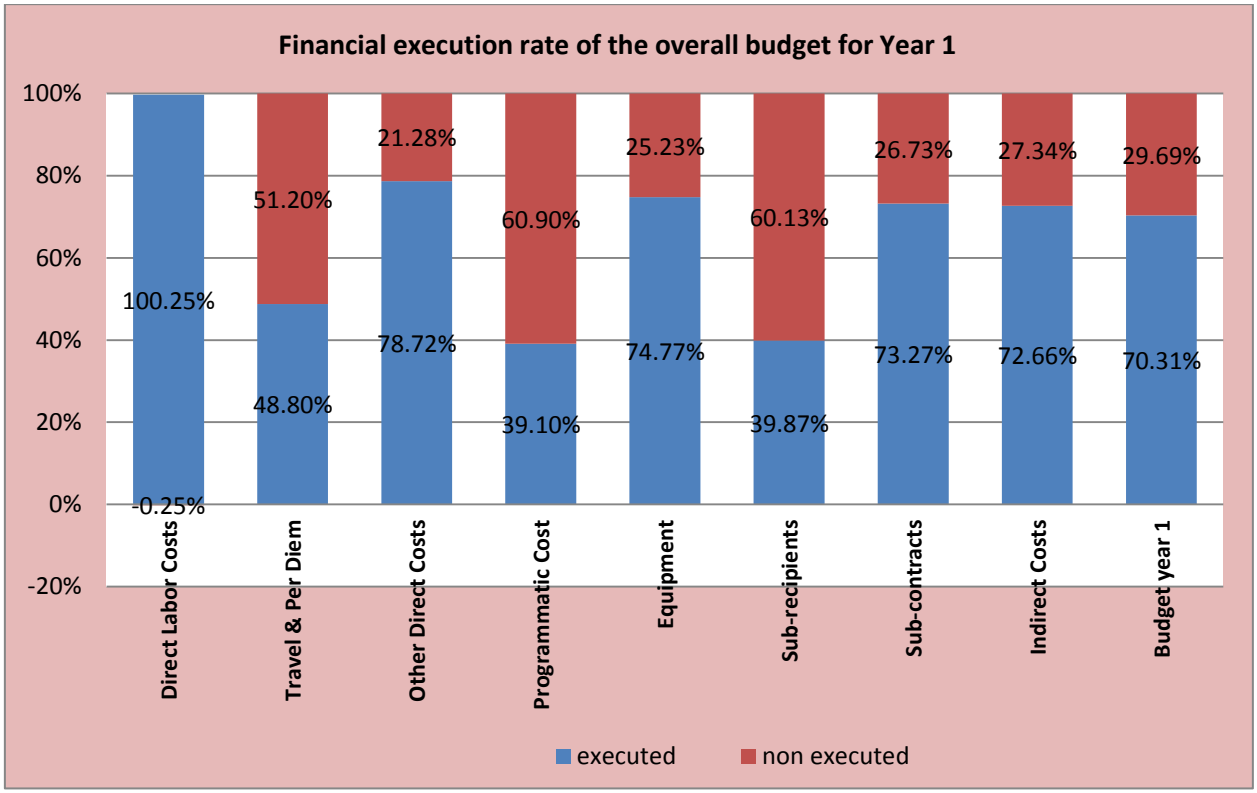
- There were delays in the signing of the order establishing the PBF project and in the setting up of project management bodies at the regional level. Moreover, performance contracts could not be signed during the third quarter due to the late conduct of the baseline survey. The unavailability of the BAP and the CTGP also had an impact on the preparation of joint audit missions.

- The strike being conducted by labor unions in the health sector and their decision to withhold health information resulted in an inadequate coverage of PBF in pilot districts.

3. Finances

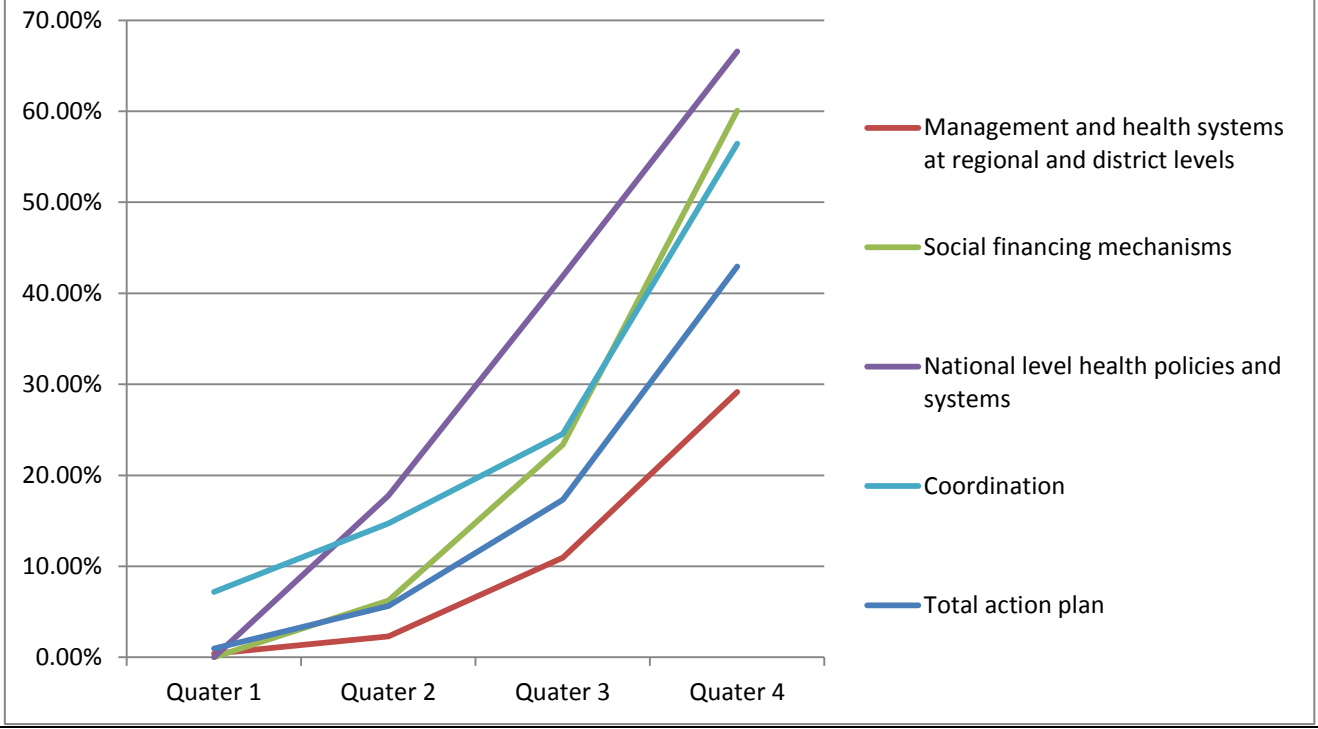
At the end of the first year, total expenditures of the H2S Component amounted to USD 3,060,567 out of an annual budget of USD 4,352,698, representing an overall execution rate of 70.31%. A significant increase in the execution rate was indeed noted during the last two quarters. It rose by 12 points between the second and third quarters and by 21.56 points between the third and fourth quarters. This increase is reflected in all budget headings except those relating to activities of the action plan and sub-contractors (see financial report attached).

The financial execution rate of the action plan is 42.93%. This is due to the delay in the finalization and approval of the annual action plan. The political environment that prevailed during the first two quarters also delayed activity implementation on the ground. Moreover, certain PBF-related activities that account for a large portion of the action plan budget could not be conducted. The budget allocated for the implementation of the PBF baseline household survey was not mobilized following the decision to utilize data from the continuous survey being conducted by ANSD. Furthermore, funds earmarked to pay performance bonuses under PBF are yet to be utilized and this activity has been moved to the action plan for Year 2. Negotiations with DAGE are however underway to transfer these funds to the PBF account of the MOH.



The level of implementation of the action plan increased significantly during the last two quarters. The financial execution rate of the action plan increased from 5.62% to 42.93% between the second and fourth quarters, i.e. an increase of 37.31 percentage points. This is reflected in all sub-components except the "Management and health systems at the local level" sub-component for reasons given earlier.

Evolution in the implementation of the action plan for Year 1



4. Guidelines and priorities for Year 2

Changes in the environment of the H2S Component. The annual action plan for Year 2 of the H2S Component will take into account changes in the sector and progress made during Year 1 of the Component. The 2012 presidential elections brought new authorities to power who have identified governance and universal health coverage as among the highest priorities on their political agenda. Furthermore, central and regional services of the MOH are currently being reorganized with the establishment of: (i) the Department of Public Health, (ii) the Department of Planning, Research and Statistics, (iii) the Support Unit for Universal Health Coverage, and (iv) the Regional Departments of Health. In order to fit its priorities to these changes, the MOH is currently holding national consultations on health and social action (CONSAS) to discuss major themes such as health system governance and universal health coverage. Finally, USAID/Senegal is committed to implementing a package of reforms relating to the way it does business, including the *Implementation and Procurement Reform (IPR)* which introduces direct financing mechanisms at the central and regional levels with the support of implementing agencies.

General guidelines and priorities of the H2S Component for Year 2. In light of the above, the annual action plan for Year 2 sets the stage for the H2S Component to seize opportunities provided by the changing environment to improve health system performance, focus on the practical application of planning, management and financing instruments jointly developed by all Health Program components during Year 1, and maintain flexibility to ensure action plan interventions are in line with the outcome and recommendations of national consultations on health and social action (CONSAS). Based on these general guidelines, the following priorities directed the development of the 2012-2013 action plan:

- Consolidation of PBF in the three (3) pilot districts and extension to four (4) new health districts;
- Implementation of the Direct Financing pilot phase in regions where the Health Program's regional bureaus are located;
- Extension to all focus regions of activities relating to the strengthening of management and monitoring capacities of medical regions and health districts;
- Consolidation of the social financing mechanisms' strategic support framework;
- Consolidation of the project to expand health insurance coverage within a decentralization context (DECAM project) in focus departments;
- Development of the community health policy;
- Advocacy work to reposition family planning;
- Strengthening the capacities of the National Medical Store (PNA) and the availability of drugs at the operational level;
- Consolidation of the Health Policy Initiatives Group (EIPS) and the Medium Term Expenditure Framework (MTEF) for the health sector as part of on-going organizational reforms within the MOH;
- Strengthening synergies between Health program components.

Attachment 1: Financial report of the Component

Execution of the overall budget for Year 1				
Description	**Budget**	**Cumulative spending for Year 1**	**Balance for fiscal year 1**	**% of annual budget executed**
Staff costs	$ 1 321 699.54	$ 1 325 029.23	$ (3 329.69)	100.25%
Travel	$ 78 236.66	$ 38 177.61	$ 40 059.05	48.80%
Other direct costs	$ 507 914.56	$ 399 832.53	$ 108 082.03	78.72%
Activities	$ 559 382.57	$ 218 743.47	$ 340 639.10	39.10%
Equipment	$ 287 324.83	$ 214 843.83	$ 72 481.00	74.77%
Sub-contracts	$ 909 858.65	$ 362 789.65	$ 547 069.00	39.87%
Contracts	$ 176 299.82	$ 129 167.04	$ 47 132.78	73.27%
Indirect costs	$ 511 981.89	$ 371 984.37	$ 139 997.51	72.66%
Total	**$ 4 352 698.52**	**$ 3 060 567.73**	**$ 1 292 130.79**	70.31%

Execution of the action plan budget for Year 1				
Annual action plan of the Health System Strengthening Component		**Cumulative spending for Year 1**	**Balance for fiscal year 1**	**% of annual budget executed**
Line of action	**BUDGET CFA F**			
Sub-Component A: Management and health systems at regional and district levels				
Enhanced capacities of RHMTs and DHMTs in governance and leadership	26,512,800 CFA F	12,551,100 CFA F	13,961,700 CFA F	47.34%
Strengthening the planning process at regional and district levels	18,530,800 CFA F	7,094,973 CFA F	11,435,827 CFA F	38.29%
Enhancement of financial management capacities of regional and district management teams	2,000,000 CFA F	- CFA F	2,000,000 CFA F	0.00%
Direct financing mechanisms	7,567,200 CFA F	1,586,900 CFA F	5,980,300 CFA F	20.97%
Support to the drug supply system at regional and district levels	- CFA F	- CFA F	- CFA F	
Consolidation of monitoring/supervision mechanisms at regional and district levels	6,250,000 CFA F	3,493,450 CFA F	2,756,550 CFA F	55.90%
Support to implement performance-based financing	145,272,510 CFA F	35,414,951 CFA F	109,857,559 CFA F	24.38%
TOTAL SUB-COMPONENT A	**206,133,310 CFA F**	**60,141,374 CFA F**	**145,991,936 CFA F**	**29.18%**
Sub-Component B: Social financing mechanisms				

Execution of the action plan budget for Year 1				
Annual action plan of the Health System Strengthening Component		**Cumulative spending for Year 1**	**Balance for fiscal year 1**	**% of annual budget executed**
Line of action	**BUDGET CFA F**			
Strengthening of financial support mechanisms (FNSS, Guarantee fund)	12,000,000 CFA F	7,005,193 CFA F	4,994,807 CFA F	58.38%
Setting up and restructuring of MHOs (DECAM pilot phase)	52,237,500 CFA F	32,069,763 CFA F	20,167,737 CFA F	61.39%
Protection of other vulnerable groups	10,000,000 CFA F	5,508,100 CFA F	4,491,900 CFA F	55.08%
TOTAL SUB-COMPONENT B	**74,237,500 CFA F**	**44,583,056 CFA F**	**29,654,444 CFA F**	**60.05%**
Sub-Component C: National level health policies and systems				
Strengthening of capacities for reform management (EIPS)	11,797,500 CFA F	14,923,225 CFA F	(3,125,725)CFA F	126.49%
Drafting of policy papers	5,550,000 CFA F	3,074,375 CFA F	2,475,625 CFA F	55.39%
Reform implementation	6,050,000 CFA F	- CFA F	6,050,000 CFA F	0.00%
Support to monitor and evaluate the PNDS	9,500,000 CFA F	3,398,900 CFA F	6,101,100 CFA F	35.78%
Implementation of the health sector's MTEF	8,775,000 CFA F	6,348,200 CFA F	2,426,800 CFA F	72.34%
			- CFA F	
TOTAL SUB-COMPONENT C	**41,672,500 CFA F**	**27,744,700 CFA F**	**13,927,800 CFA F**	**66.58%**

Execution of the action plan budget for Year 1				
Annual action plan of the Health System Strengthening Component		**Cumulative spending for Year 1**	**Balance for fiscal year 1**	**% of annual budget executed**
Line of action	**BUDGET CFA F**			
Sub-Component D: Coordination				
Management and functioning of regional bureaus	14,055,100 CFA F	5,962,603 CFA F	8,092,497 CFA F	42.42%
Annual joint planning	1,000,000 CFA F	1,943,323 CFA F	(943,323)CFA F	194.33%
Implementation of an integrated monitoring and evaluation plan	27,625,100 CFA F	16,187,367 CFA F	11,437,733 CFA F	58.60%
TOTAL ACTIVITY AREA D	**42,680,200 CFA F**	**24,093,293 CFA F**	**18,586,907 CFA F**	**56.45%**
Total Action Plan	**364,723,510 CFA F**	**156,562,423 CFA F**	**208,161,087 CFA F**	**42.93%**

Attachment 2: Indicators of the H2S Component

The H2S Component prepared and submitted to USAID for approval its performance monitoring plan (PMP) based on sixteen (16) indicators. These indicators, which track the level of progress in achieving the expected results of the Component, are presented in the following table.

To establish a baseline situation and provide information on indicators, a joint data collection and supervision mission visited the ten regions covered by the Component. The team comprised the M&E adviser and a representative of CRDH. They collected data for indicator 1, conducted a review of indicator 2, assessed AWP monitoring in health districts, sought the opinion of chief regional medical officers and regional bureau coordinators on the conduct of JPRs, and assessed information on MHOs. This mission was conducted in conjunction with regional bureaus, which supplied or prepared most of the data. Regional bureaus also introduced the data collection team to RMOs and occasionally accompanied the mission. At the end of this mission, a database with information per district was developed.

Information regarding the share of the national budget allocated to the health sector and the MTEF-Health performance report was obtained from DAGE/MOH. Targets relating to the share of the national budget allocated to the health sector were determined based on the practice observed in Senegal of increasing the health sector budget by 0.5% each year. National advisers provided the data for other indicators. Most baseline data was obtained from the report of the Healthcare financing and policy component of USAID's 2006-2011 Health Program.

Difficulties were encountered to obtain data on certain indicators particularly the baseline data for indicator 3 (proportion of health districts with a financial execution rate of AWPs higher than 80%) and for indicators on MHOs.

Indicator 3 was not monitored during the previous program and therefore the data had to be reconstituted. However this could not be completed on time but will be continued and the information provided when presenting the 2012 situation in 2013.

Regarding MHOs, information dates back to November 2011 for some regions and August 2012 for others. Since the fiscal year is spread over 2011-2012, the data was aggregated in order to have a reference for the period.

Values that were not available at the time of preparing the table can be identified by the term “Not Determined” (ND). Values that are not applicable are identified by the term “Not Applicable (NA): for example the number of MHOs that have received public subsidies following the establishment of mechanisms by the government can only exist if planned mechanisms are already in place.

Indicators	Reference 2011	Target 2012	Fiscal year results 2011-2012	Targets				Observations
				2013	2014	2015	2016	
Indicator 1: Proportion of health districts where the functions of DMO and those of the chief medical officer at the health center are separated	ND	ND	19%	25%	30%	35%	40%	Regulatory acts are yet to be adopted at the central level even though there are some personal initiatives in this area which can however not be extended to the point of delegating signing authority as it is not provided for by legislation; it is worth noting that of the 52 health districts covered by the Component, less than half (22) have more than one physician; the target defined by PNDS can only be taken into account if the relevant pieces of legislation are signed; meanwhile a 5% increase is planned.
Indicator 2: Proportion of Service Delivery Points (SDP) that have displayed the tariffs of drugs and services	73%	95%	55%	95%	95%	95%	95%	Information is obtained from data collected on good governance indicators between July and August; integrated supervisions are not conducted on a regular basis hence the decline in this rate; it should however be noted that a rate of 68% has been reached for the 5 regions covered by the former program.
Indicator 3: Proportion of health districts with a financial execution rate of AWPs ≥ 80%	ND	100%	ND	100%	100%	100%	100%	The 2012 AWP execution rate will be announced in 2013; reference data will be available then

Indicators	Reference 2011	Target 2012	Fiscal year results 2011-2012	Targets				Observations
				2013	2014	2015	2016	
Indicator 4: Number of medical regions that have organized a high quality JPR	100% in 2011	100%	100%	100%	100%	100%	100%	Despite the decision of unions to withhold information, participants were able to discuss indicators using the 2010 DHS and on-going data collections; furthermore most partners participated
Indicator 5: Number of audit reports delivered on time	NA	100%	0	100%	100%	100%	100%	The project commenced in April and the conduct of joint audit missions was delayed owing to the time taken to select the audit firm and CBOs
Indicator 6: Proportion of reimbursement requests paid on time	NA	100%	0	100%	100%	100%	100%	Payment requests for the project which commenced in April were not transmitted due to the delay in conducting joint audit missions
Indicator 7: Number of health districts involved in performance-based financing	NA	3	3	7	NA	NA	NA	The project commenced in April; it should however be noted that the District of Darou Mousty has not signed a PBF contract because of the call from labor unions to withhold information; targets are yet to be defined beyond 2013
Indicator 8: Number of MHOs that received public subsidies following the establishment of mechanisms by the government	NA	NA	NA	NA	50	100		Mechanisms (National fund for social solidarity, National guarantee fund and the Administrative Authority on social mutual assistance) are not yet in place

Indicators	Reference 2011	Target 2012	Fiscal year results 2011-2012	Targets				Observations
				2013	2014	2015	2016	
Indicator 9: Number of beneficiaries covered by community-based MHOs	182842	ND	263 343	330 000	410 000	510 000	650 000	Beneficiaries in regions covered by the former program represent 66% of all beneficiaries (173,186); targets were set based on an annual increase of 25% in comparison to 2012 albeit a 40% increase was recorded between 2011 and 2012; this seemed to be a more reasonable figure given that the MOH is yet to adopt the necessary legislation for the development of MHOs
Indicator 10: Number of vulnerable persons covered through MHOs with the support of a third-party payer	21 862	ND	22 438	33 000	41 000	51 000	65 000	Vulnerable persons with health coverage in focus regions of the former program represent 90% of all vulnerable persons covered (20,214); targets were set based on a 10% quota
Indicator 11: Number of policy papers approved and regulatory acts adopted for the implementation of policy initiatives developed by the EIPS	2	≥ 1	13	≥ 1	≥ 1	≥ 1	≥ 1	This includes both regulatory acts adopted at the country level (decree establishing the PBF project, office memos on the BAP, the establishment of regional bureaus, community health, national consultations and drug supply) as well as those adopted by governors for the establishment of PBF/CRG (3 orders) and *préfets* for the establishment of DECAM departmental monitoring committees (4 orders)

Indicators	Reference 2011	Target 2012	Fiscal year results 2011-2012	Targets				Observations
				2013	2014	2015	2016	
Indicator 12: Health sector budget as a percentage of the national budget	13,6%	8%	10,2%	10,7%	11,2%	11,7%	12,2%	This percentage concerns operating expenses only. The baseline data relates to the 2010 budget and current data to the 2011 budget (the budget year overlaps the program's fiscal year); from 2013, targets are calculated on the basis of an annual increase of 5% compared to the 2012 results
Indicator 13: Deadline for production of the performance report of the MTEF/Health for year n-1 is met (May)	No	Yes	Yes	Yes	Yes	Yes	Yes	The preliminary report was produced in May as scheduled
Indicator 14: Amount allocated (in CFA francs) to districts and medical regions by Program components through the direct financing mechanism	NA	NA	NA	519 400 000	NA	NA	NA	This mechanism will be employed from 2013 for the 3 pilot regions (Kaolack, Kolda and Thiès); targets for subsequent years will be defined by USAID

Indicators	Reference 2011	Target 2012	Fiscal year results 2011-2012	Targets				Observations
				2013	2014	2015	2016	
Indicator 15: Amount allocated (in CFA francs) to districts and medical regions by Program components through PBF mechanisms	NA	96 312 310	0	272 581 500	NA	NA	NA	83,999,810 CFA francs provided by Abt and US$24,625 by ChildFund in 2012; reimbursements are yet to be effected as a result of the decision of unions to withhold information and the delay in the recruitment of the audit firm and CBOs
Indicator 16: Proportion of progress reports of the Component prepared within the required time-limit	100%	100%	100%	100%	100%	100%	100%	The first, second and third quarterly progress reports were submitted on time